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Maine Medical Association meets at Portland, June, 1919

THE JOURNAL



Maine Medical Association.

The Official Organ of the State and County Medical Societies.

VOL. IX, No. 1

AUGUST, 1918.

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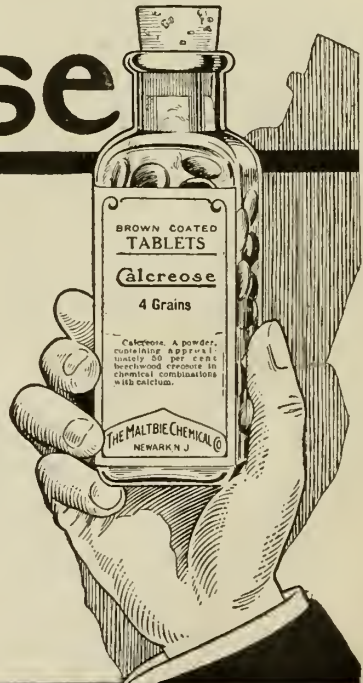
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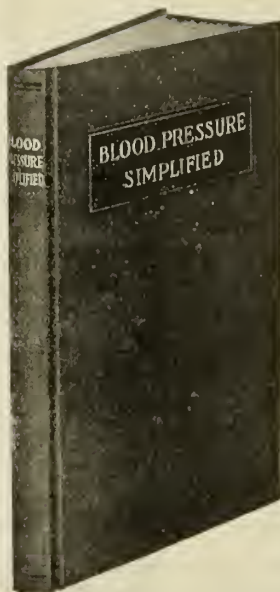
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No. 1

**NON-SPECIFIC ARTHRITIS FROM GENITO-URINARY
INFECTIONS.**

BY CLINTON N. PETERS, M. D., PORTLAND, MAINE.

In the present-day conception of the rheumatic series of infections and the frenzied search for the hidden focus, it seems fitting to depart for a few minutes from the incessant whirl of the X-ray outfit and the wholesale sacrifice of useful molars, and consider the possibilities that the genito-urinary tract offers to the elusive germ as a comfortable abode in which to elaborate toxins until some prying medical man shall oust him to the infinite relief of a discouraged patient.

Four cases seen during the past year have led me to believe that in the routine examination of cases of arthritis, unless some special symptom calls the attention of the practitioner to the genito-urinary system, there is little possibility of his considering this as a source of trouble, and only after exhaustive search of every bodily function and copious dosing with gunshot prescriptions fail to give either information or relief, some individual, as a last resort, makes a rectal examination of the prostate and vesicles and brings to light the probable focus of infection.

I do not intend to infer in any way that genito-urinary infections are the only cause or even a common cause of joint inflammations but simply to urge that in the routine examination, where there seems likely to be a focal infection causing the trouble, that the palpation of the prostate be not passed by as a measure too disagreeable to accomplish any good, and to prove to you by case reports that such an infection not only exists but may be a direct cause of the so-called rheumatism of the laity, and that appropriate treatment of this cause will materially improve the general condition.

We are well acquainted with the existence of gonnorrheal arthritis, and from this it is not a great step in accepting the statement that other organisms, located in the same region, may produce similar conditions by toxin elaboration. The main question is how these organisms get to the genito-urinary tract.

In the localization of any infection we have existing conditions called predisposing causes. In the order of their importance these are:

1. Situation of the part.
2. Lowered vitality of the part.
3. Injury to the part.
4. Disturbed circulation of the part.

Ideally located to pick up infection from the urethra, bladder, kidney and rectum, constantly subjected to specific infection, congested or devitalized by either a too passive or a too active sexual existence, it is one of the marvels of nature that the prostate gland and seminal vesicles are not more often the seat of severe infection.

A large percentage of men go through the various stages of gonnorrheal infection, with a great variety of treatment from individual physicians to individual drugstores, and a great many times finally end with a chronic infection steadily irritated by local application of advertised nostrums. A certain percentage have actual infection of the prostate vesicles and even epididymes. The majority are left with a permanently damaged urethra, and should they be resistant enough to overcome the specific infection, there practically always ensues tissue invasion by some of the more chronic organisms of milder nature, which condition exists for years with periods of quiescence and exacerbations.

Granting that toxins and focal infections are a cause of joint symptoms, is there any reason why infections in the prostate and seminal vesicles may not cause arthritis as well as focal infection in the alveolar process? My answer is this: No, there is no reason, provided there is absorption; and that the condition is not more common is due to the fact that the drainage of the part is usually good. However, when drainage of the part is interfered with materially, then absorption may and generally does take place, and it is due to the interrupted drainage that we get our symptoms.

Lessened calibre of the urethra or inflammatory fibrosis of the prostatic tubules and ducts of the seminal vesicles are the chief causes of interrupted drainage of the part. Of these the urethral stricture is the more common and more likely to produce a subacute state of absorption when accessory to the above infection. The dilated portion behind the stricture is a source of constant danger to the bladder, and the bacteria extend to this organ and even to the kidney if the back

pressure is sufficient to cause a dilatation of the ureteral orifices. The whole condition may be so gradual that the patient does not attribute importance to his diminishing urinary stream and increased effort in voiding. That he does not associate it with his joint trouble is not to be wondered at.

Inflammatory fibrosis of the prostatic ducts and openings of the seminal vesicles is always present to some degree, but in this class of cases never sufficient to obliterate their lumen. Generally speaking, the condition shows just enough thickening of the part to keep the mouths of the tubules partly open, allowing the septic material to be deposited in the urethra at each muscular effort of the patient in the act of micturition or defecation. Should complete closure of the prostatic tubules ensue, an acute condition would likely follow, directing the attention of the patient to the part involved. Closure of the ejaculatory duct is never found. To repeat, the pathological findings in this class of cases are usually:

1. A non-specific infection of the prostate and seminal vesicles.
2. Inflammatory fibrosis of their ducts near the urethral opening.
3. Extension of the infection to the posterior urethra and bladder.
4. Partial stricture of the urethra, materially disturbing drainage.

Dr. J. T. Geraghty, in a paper on seminal vesicle infections, from the Brady Urological Institute at Johns Hopkins, says regarding the diagnosis: "The seminal vesicles are much more commonly the cause of persistent bacillary and coccal infections of the urine than is generally supposed.....The fixing of the responsibility on the seminal vesicles as the source of continued or recurrent infections is not always easy. In many cases the presence of a vesiculitis may be readily determined by palpation, but it is surprising what a large percentage of infectious, active foci are present in one or the other vesicle and still careful palpation may reveal very few changes."

This, of course, complicates the diagnosis, but as we always find an infected bladder in these conditions, and we know that bladder infections are usually secondary, and that there are only two sources of infection—above in the kidney, or below in the prostate and vesicles—where there is the least suspicion of involvement of these parts, urethral examination for stricture and catheterization of the ureter will give us definite information.

Regarding arthritis from infection in this location the literature

I have been able to find is very meagre. Dr. Robert R. Herbst, of Chicago, in a paper on seminal vesicle infections, speaking of the results of chronic vesiculitis, says: "Systemic manifestations and joint involvements are always possibilities during the continuance of such infections." In a discussion of papers by Geraghty, Stokes and Herbst, Dr. E. O. Smith, of Cincinnati, gives the following case history and criticism of the neglect of these men to mention arthritis. His contribution is as follows:

"Dr. Geraghty's discussion of the seminal vesicles as a seat of infection is well taken, and all of us are familiar with the frequency with which this condition occurs. He did not mention one of the remote symptoms, which has been overlooked many times, and that is arthritis. We have here a focus of infection that sometimes escapes notice, as is illustrated by a patient sent to me some time ago for a persistent arthritis, most evident in the lower extremities. It had been going on more or less for two or three years. He had been to health resorts and had had many sorts of treatment. A surgeon put arches in his shoes. This did not relieve him. He was sent to a dentist and had a large amount of expensive bridgework removed, but this did not relieve his arthritis. Some months later he was sent to me for examination of the seminal vesicles and prostate. We found involvement of these structures, and put him on suitable treatment—massage, irrigation, vaccines—and the arthritis cleared up very promptly."

In the treatment of the condition we attempt two principles, to re-establish the drainage and combat the infection. Dilatation of the urethral stricture, prostatic massage and stripping of the vesicles will aid most cases. If the condition should be severe, drainage of the vesicles has been brought about with great benefit, but is an operation of last resort. Regarding this procedure Dr. A. C. Stokes says: "Seminal vesiculotomy is rarely indicated, and should not be done except in those cases in which there is an empyemic vesicle with signs of sepsis and no tissue destruction."

Much improvement can be obtained by the more simple procedure Vaccine therapy is indicated. A urinary antiseptic is most useful, and bladder irrigations at the time of dilatation and massage will tend to alleviate the trouble.

Following is a brief history of three of the four cases which I have had here during the last year. The pathology is similar, although the general location of the pain differs in each case.

CASE 1.—Mr. M., laborer, 52 years old. Widower, three children. *Past History.* Alcoholic; is a periodic drinker. Twenty-five years ago had a fall, landing on the neck and shoulders. Was disabled for

some time, but finally recovered. Has had typhoid and children's diseases. Denies syphilis. Has had several attacks of gonnorrhea, the last twelve years ago. Has been troubled by rheumatism for several years. *Present History.* Four months ago his rheumatism became so bad that he saw the doctor, who gave him some tablets. Pain in the lumbar region and in the neck. The pain became so severe that he could not sleep and caused him agony when he turned his head. In stepping down from the curbing or stairs a severe pain shoots from the cervical region to the occiput. For the last two months has been unable to do any work, and spends the night walking the floor until he is exhausted. Has lost much weight. For the last month has been treated at a charitable institution in this city. Results have been negative, and the condition is progressively growing worse. Advised to have teeth out, but dentist says they are good. *Physical Examination.* Shows a spare man, weight 135, good muscular development. Chest and abdomen normal; head normal; extremities normal. Tonsils atrophied slightly, teeth in fair condition. Limited motion of neck in all direction. Pain on pressure at about the fifth cervical. Some slight abnormality felt in this region caused me to have an X-ray plate made, which showed an old fracture at this point. A leather collar was thought the thing and so advised to the patient. The case nearly stopped here and probably would have except I had made no urinalysis and asked the patient to pass some urine for me. Much was my chagrin to see him pass a very fine stream with apparent great effort. I examined the urethra and found a stricture of small calibre. The prostate and vesicles were indurated and tender, and the secretion showed much pus. *Treatment.* I dilated the stricture gradually massaged the prostate and vesicles and put the patient on aspirin and hexamethaline and acid sodium phosphate. This, with irrigations of nitrate of silver, brought the following result. The patient never bought his leather collar. At the end of the first week he felt much improved. At the end of the second week he went back to work. At the present time, nearly a year has elapsed and he has worked every day. I have him report once a month for dilatation and massage, and while the condition is not entirely cured and never will be, he gets along very well. He has some pain in the lumbar region at times, but no trouble in his neck except limited motion from the old fracture.

CASE II.—Referred to me for stricture of the urethra. Mr. D., carpenter, aged 27 years. Married and one child. *Past History.* Several attacks of gonnorrhea in the past. Has not had urethral discharge for a long period. Is bothered with rheumatism of the hands, so has been unable to work at his trade for the last year. *Present*

History. His urine has been bothering him for some time and gradually taking more effort to void. Three months ago it stopped for twenty-four hours after he had indulged in some whiskey. This cleared up without treatment, but at the present time he has frequency and burning and can pass but a few drops at a time. *Physical Examination.* Good physical condition. Nothing abnormal except joints of first two fingers and thumb. These were much swollen and very painful. Prostate was tender and vesicles indurated. Urethra had stricture of small calibre. Patient did not associate the two conditions; but thought his rheumatism had been much worse since his urine had commenced to bother him. No urethral discharge. No gonococci present. *Treatment.* I passed a small bougie into the urethra and bladder and irrigated the bladder as best I could. Next day the patient came into my office with a temperature of 102 and said he had had a chill. I put him in bed for two weeks and gave salicylates and gradually dilated the stricture. Also used 5% argyrol in the bladder. During the treatment he had an acute exacerbation of his arthritis and showed some temperature for several days. This gradually subsided and the condition of the joints improved as I enlarged the calibre of the urethra. The patient reports about once a month for massage and dilatation. There has been no return of the painful joints for eight months. At present his urethra will take a 25 French sound easily and the prostatic secretion is fairly free from pus.

CASE III.—Referred to me for prostatic treatment. Mr. C., 45 years old. Married. *Past History.* Always been well. Had gonorrhea about twenty years ago and has had persistent discharge recurring ever since. *Present History.* Complains of sharp pain in the left groin; also pain in sacroiliac joint, and in the right shoulder joint. The sacroiliac pain is severe at times, and as he is on his feet a large part of the time, bothers him greatly. The groin pain is spasmodic. *Physical Examination.* General physical condition is excellent. Slight urethral discharge shows pus and few organisms. Stricture of the urethra found about four inches from the meatus. Prostate tender and left vesicle hard and painful. No gonococci present. *Treatment.* Massage of the prostate and vesicle, with dilatation of the stricture has stopped the discharge, and the pain in the sacroiliac joint has ceased. The patient is under treatment at present and feels much better. The pain in the groin is much less frequent.

INDISCREET REMARKS BY DOCTORS IN MALPRACTICE CASES.

BY DR. H. T. WESTON, HARTFORD, CONN.

I greatly appreciate the compliment that has been extended by your Association in asking me to address you upon this subject.

During the past four years I have had an opportunity of observing the intimate details that have arisen in approximately three hundred claims for damages against physicians and surgeons, dentists and hospitals. In a majority of these cases our investigation has disclosed that some doctor, for some reason, has made a remark substantially as follows: "Who has been taking care of this case?" or "I am so sorry that I did not have an opportunity to attend this case in the first place," or "I am afraid your case has gotten into such shape now that it will be impossible for me to remedy your trouble. Of course the result might have been entirely different if you had come to me in the first place," or "Dr. Blank ought to be ashamed of himself, to let you get into this condition." A charitable construction to be placed upon remarks such as these would be that they were made through thoughtlessness and ignorance of the effect that they were bound to have. There have been, however, such a number of cases arising as to justify us in concluding that certain doctors have made comments to their patients with the deliberate intent to cause suits for damages to be brought against other men, through what would seem to be pure spite and envy.

I believe that you will agree with me that the men who permit their personal or professional prejudices to dictate their acts, in this or any other connection, are to be pitied, and, if possible, shown the errors of their ways before they are condemned or any drastic measures taken, looking toward convincing them that it is not to their best interests to let their personal feelings prejudice the interests of their profession. I leave the matter of the best method of handling this last referred-to class of men to the consideration of your members as a whole, and hope that you can evolve and adopt such methods as will do away entirely with such a regrettable attitude being held by any of the members of your profession, either within or without your society organization. So far as the heedless or careless man is concerned, I hope that I may be able to bring home to you the effect of these remarks upon the standing of your profession and your members in the community, and I trust that, as a result of calling attention to this matter, more thought and care will be taken by each of your members before any more careless or heedless remarks are made.

It is certainly regrettable that in your State your profession has been subject to attack so frequently, and over such a long period of years. Possibly the most notorious, vindictive and persistent malpractice case on record is that of Lowell vs. Faxon and Hawkes, which was referred to in the paper prepared by Dr. James A. Spalding of this city, and published in the *Bulletin of the American Academy of Medicine*, February, 1910. It may be that many of your members have never been conversant with this case, therefore a brief statement would be of interest to them, and I quote from the article written by Dr. George W. Gay of Boston, published in the *Boston Medical and Surgical Journal*, September 7th and 14th, 1911, as follows:

"In 1821 Charles Lowell, of Lubec, Maine, aged twenty-one, was injured by a horse falling on him in such a manner as to separate his legs forcibly and injure his left hip. The local physician, Dr. Faxon, not being able to reduce the deformity, called Dr. Hawkes, of Eastport, in consultation. Their diagnosis was a dislocation of the hip. Efforts at reduction by manipulation were made for about half an hour, when a grating sensation was felt by the patient and the physicians. An examination then showed the legs to be alike in length, position and motion, indicating a successful reduction of the deformity. The legs were fastened together with bandages, the patient was bled, as was the custom in those days, and given an opiate.

"Fourteen days later the patient got out of bed of his own accord and walked 'a long distance home.' Six weeks after the accident the injured limb was found to be abducted, lengthened and the foot everted, indicating a dislocation of the head of the femur downward. On being told that nothing could be done to remove the deformity, he at once came to Boston and consulted Dr. John Collins Warren, the leading surgical authority of New England, and several other well-known surgeons, who generally corroborated the diagnosis of Dr. Warren and the Maine physicians. Efforts were made at the Massachusetts General Hospital, which had just been opened to the public, and elsewhere in Boston, to reduce the dislocation by means of pulleys, etc., but without success.

"Lowell returned home and with the most violent and vindictive temper began a fight against his physicians and the profession generally, which lasted the remainder of his life, nearly forty years. He brought suit against Drs. Faxon and Hawkes in the sum of \$20,000. The jury gave him \$1,963. An appeal was taken and the second jury disagreed. At the third trial Dr. Faxon was acquitted, but while the jury was considering Dr. Hawkes' case, one of the jurors was taken suddenly ill. The chief justice, being in town, concluded that, as there

was little prospect of a verdict from further trials, 'the best thing for all parties was for the plaintiff to accept non-suit and the defendant to take no costs.' Thus ended a five-years' fight in the courts, but by no means was that the last note of it. By innumerable letters, several pamphlets and an endless stream of talk, all of the most virulent and vituperative character, Lowell kept up the fight as long as he lived. Dr. Warren, the leading authority in the case, was forced, much against his inclination, to issue a pamphlet in his defense in the form of an open letter to Chief Justice Isaac Parker, of Massachusetts, giving, among other facts, his reasons for his opinion of this most troublesome and vexatious case.

"There was a difference of opinions as to the exact nature of the injury. While most of the surgeons agreed that it was a dislocation of the hip, a few, among whom was Dr. Nathan Smith, thought it might be a fracture of the acetabulum. Dr. Warren stuck to his anatomy, clinical symptoms and his common sense and insisted that it was a dislocation downward of the head of the femur.

"Thirty-seven years after the accident, Lowell died, and in accordance with his orders, an autopsy was made and the results proved the correctness of the diagnosis of a downward dislocation of the hip. There was no evidence of any fracture. The pelvis and femurs are in the Warren Museum of the Harvard Medical School."

Possibly this case, occurring so early in the history of Maine, has had a direct effect upon and can be held responsible for much of the subsequent malpractice litigation in your State. From all we can learn, it appears that there are many more malpractice cases tried in the courts of Maine than are tried in any other State in proportion to its population. It is true that up to a short time ago there were but few judgments recovered in cases upon which your Supreme Court was called upon to pass—this undoubtedly because your Supreme Court has the power of reviewing the evidence and considering the credibility of the witnesses—but our experience indicates that we can no longer depend upon the Supreme Court to follow former practices; in fact, in one of their recent decisions they used substantially these words: "There was the usual conflict of expert medical testimony, but we deem these matters for the jury." If this dicta is accepted and followed in the future by your Supreme Court, you may expect that many judgments and jury verdicts against the doctors will be affirmed where in the past they have been set aside.

My personal experience while attending trials of malpractice cases in this State, as well as other States in the Union, has convinced me that it is an impossible task to undertake to educate a jury to ap-

preciate questions of medicine or surgery, and while it is true that, by the most careful preparation and with the utmost care in the way in which the evidence is presented, it is possible at times to secure a jury verdict for the defendant, yet to depend upon this result is for the medical profession to lean upon a straw, and the result would be inevitable.

The attitude of your Supreme Court only emphasizes the general trend of the courts throughout the country. In some communities the general sentiment is that a well-known physician should not be attacked, but in other communities it would seem that no matter what the reputation that has been gained by the practitioner in the community is, if a claim is brought against him, and a suit tried, the jury and court seem to consider that the only question upon which the verdict is to be based is who has the most money, with practically a uniform result, that if the doctor has a reputation of having accumulated a reasonable competence from his practice, he is many times on this account alone elected as a victim, and of course, unless there has been gross error committed in the trial of the case, and the verdict is in direct violation of the law governing the trial and the court procedure, there is but little hope for a reversal, although sometimes we are able to secure a remand for a new trial, at which the defendant is usually at a disadvantage.

There is another disadvantage under which the medical profession is laboring in these cases at the present time, namely, that the Compensation Law in your State, and in many other States in the Union, has deprived the attorneys who formerly sought their practice among injured employees as their principal source of income of that class of business, and these men are now seeking other classes of tort cases from which to make a living. The effect of these conditions is already apparent, and the profession must expect many more cases to develop than have in the past, also that the class of attorneys prosecuting these cases will be more adroit and possibly unscrupulous; at least, they will have had more experience. We therefore expect that it will be much more difficult in the future to win these cases to the jury than it has been in the past.

On account of the conditions that confront your profession, I believe that you will agree with me that every member of either the medical or dental profession should be impressed with the idea that he should use the utmost care to prevent any patient from believing that he had not received the proper care and the benefit of the best judgment of his attendant, while being treated prior to his reaching your hands. I also desire to impress upon you the duty that you owe to the other members

of your profession, to insist upon the absolute facts in each case being submitted to you by any attorney who is attempting to build up a malpractice suit before you express any opinion. I believe that if you will do this, and you will use your influence to the end that every other professional man in your community follows the same course, that you will do away with ninety per cent. of the claims that are made against the professions in this State, for it is my firm belief that what may be termed snapshot judgments and curbstone opinions given by a doctor without full and complete information regarding the case that he is discussing, are responsible for most of the claims for damages and malpractice suits that are brought against the members of the professions throughout the country.

Closely connected with this subject is the question of presenting a defense against these claims, and if I may be permitted to digress, I desire to state that the best defense is the preservation of proper records regarding the treatment of your cases. I cannot hope to express the thought I have in mind in words more apropos than those used by Dr. Gay in the article previously referred to, with the exception, however, that the present conditions are vastly worse from the standpoint of the profession than they were in 1911, when Dr. Gay prepared his paper. He says:

"Suits for malpractice should be and very generally are discouraged by all right-minded people. The better class of attorneys hesitate or refuse to accept service therein, realizing the fact that the few just claims can usually be adjusted outside of courts and that the other sort have little or no foundation in fact or justice. Making due allowance for human limitations, the cases are rare in which a respectable physician should be haled into court and made the victim of public criticism, censure and pecuniary forfeit. And, furthermore, the instances are still more rare in which it is a physician's duty, or in which he is justified, in appearing in court as an expert against a reputable practitioner who is defending himself in a suit for alleged malpractice. Reasonably faithful, skilful and conscientious service should receive the approbation and support of the members of our profession rather than their active or passive condemnation. In the interests of a 'square deal' of right and justice, the honorable physician should be safe with his fellows and associates.

"No physician is legally obliged to respond to any call for his professional services. Common humanity compels him to respond to demands that he might not accept upon other grounds, but the law has no more control over his professional services than it has over those

of any other class of people. A doctor is not a public servant, as is a policeman or a fireman.

"Having accepted service in any case, however, the law requires three things of him, to wit: 'A reasonable degree of the learning and experience ordinarily possessed by the medical men of the time and neighborhood. Reasonable and ordinary care of the case committed to him. Exercise of his best judgment in cases of doubt. These promises he takes with him to every sick room.'

"Character, education and experience are the main tests of one's fitness to practice medicine. The physician is legally and properly bound to exercise due care and skill in the treatment of his patients. Having done this, he is not responsible for the results in the case, whatever they may be.

"The law does not call for extraordinary care and skill, nor does their exhibition shield the physician from the malicious attacks of adventurers and blackmailers. The most accomplished practitioner is as liable to an action for alleged malpractice as is the most disreputable pretender in the community. No qualifications suffice to protect the physician from these assaults. Care, forethought and discretion would seem to be our only safeguards.

"The law does not sanction experiments in our profession in the care of the sick. The moment the physician departs from the usual and accepted mode of treatment of a case, he renders himself liable to action should the termination be unsatisfactory. The consent of the patient given before witnesses and duly recorded would be the best possible defense under these circumstances.

"The law aims to give every one reasonably even and exact justice. Our courts endeavor to carry out the provisions of the law to the best of their abilities, and in the interest of justice. Attorneys devote their energies to the interests of their clients without much regard to abstract justice. The courts are usually as considerate of the interests of the defendants in these common malpractice cases as is possible. Could they but have the rights and privileges of their English brethren in the judiciary, we should have little reason to fear the outcome, as few of the fake cases would ever reach the jury. Even under present conditions, the verdicts in a large proportion of cases lie with the defendants. Yet to obtain them they are put to much trouble and expense, to say nothing of the public annoyance and the whole wretched business that attends these affairs.

"While we cannot prevent claims being brought against us upon all sorts of unjust and unreasonable charges, yet we can do much to protect ourselves from disastrous possibilities resulting therefrom.

"In the first place, it is essential that the physician starts fair and right. He should undertake only such cases as he can properly manage with or without available assistance. A reasonably correct diagnosis is the basis of satisfactory clinical work, and no pains should be spared to obtain it. Prompt and repeated consultations should be requested in difficult and obscure cases for the double purpose of avoiding error and dividing responsibility. In these days of highly developed specialism, it is incumbent upon the family practitioner to avail himself of the services of experts upon all proper occasions, not only for the benefit of the patient, but for his own as well.

"As a rule it is better that the prognosis should accompany the diagnosis. Careful and explicit explanations of the nature of serious cases, together with the complications liable to arise and their probable termination, may well be given to the patient or to some reliable person early in the attendance. This for our own protection. While the conscientious physician naturally desires to spare the feelings of his patients and their friends by carrying this responsibility himself, saying nothing to anybody, yet this very consideration may lead to future embarrassment and subject him to unmerited criticism. For this reason it is better in many cases to state the facts and the probabilities frankly but kindly to some one in the presence of witnesses, all to be a matter of record. Failing to do this may lead to the suspicion later that the physician 'did not understand the case,' and hence was not justified in taking charge of the patient.

"It goes without saying that many cases are best examined under an anesthetic, but anesthetics should never be given to women except in the presence of one or more of their own sex. The records of the X-ray should rest in the hands of the family physician or his consultant, rather than be brought into the case from the outside. The evidence of the skiagram is not always consistent with clinical facts as regards the function of the structures. This is especially noticeable in certain fractures.

"The value of careful records of our cases is in evidence under many different conditions. Surgical notes are of especial importance, as these cases are more often the basis of malpractice suits than are any other. For example, should the defendant die before a suit is brought to trial, his heirs would be greatly handicapped in their defense by the lack of full notes of the case. Should the plaintiff die before the trial, the defendant would be unable to testify, unless the executor or administrator chose to do so, and he seldom does. Hence the importance of complete notes as to dates, events, names of consultants, nurses, assistants, visitors, etc.

"Furthermore, the time in which suits may be brought is so long, six to twenty years, that the defendant may have forgotten many important details necessary to his successful defense. Notes made at the time of the occurrence of the events will have more weight with everybody than if made from memory some time after the events. Under certain conditions complete notes might prevent legal proceedings, and in many other conditions may be of considerable importance.

"In the event of a suit, or of a threatened suit, the defendant should neither talk nor write letters relating to the case in question, as anything that he may say or write may be used against him in court. Employ counsel, place the matter in his hands and let him do the talking and writing, as he is protected by his position from prejudicing his client's interests. Have no communication with the plaintiff except with or through the counsel. It is the business of the attorney to manage these affairs, and he should not be hampered unnecessarily by his employer."

In this State a suit was brought against one of the most prominent orthopedic surgeons in the State, who also has a reputation outside of his own State as a successful general surgeon. He has been practicing for years in a large hospital, and has had a vast experience in the most serious class of casualty surgery, on account of the fact that the hospital is practically a clearing-house for a large area of country in which a class of hazardous industrial operations is conducted, and the cases that are brought to the general hospital have, in many instances, gotten into horrible shape, on account of the delays incident to the transportation of the injured.

The patient in this case visited the doctor for the purpose of seeking relief for excruciating pain in both lower limbs, such as prevented him from working or sleeping. He had suffered from this condition for years, and had been disabled from following his ordinary avocation as a farmer. The condition from which he had suffered had caused an almost complete anklysis of both ankle joints, only about twenty per cent. of movement remaining. He had been treated by local physicians; he had sought the advice of specialists, and he freely admitted that he intended to commit suicide if he could not be relieved of the pain that he was suffering from. Our assured advised the man that he thought that it would be worth while to try the effect of the severing of the nerve of sensation on the outside of each leg, that his loss of movement in his ankles was much greater than that which would be caused by any loss of muscular function that would be caused by the separating of the nerve, and the patient accepted the suggestion, and made arrangements for the operation to be performed. There was

some delay in the assured being able to visit the home of the patient, where the operation was to be performed, and in the interim our assured received two or three letters from the patient, stating that if he could not come and perform the operation immediately that the patient was going to commit suicide, because he had gotten beyond his ability to stand the pain. The operation was performed, and the musculo cutaneous nerve in the right leg was cut at a point about six inches below the knee, the trunk of the nerve being found in the usual position. The wound healed with no complications, and the result was entirely satisfactory, at least there was no complaint made by the patient as to the continuation of the pain previously suffered in this leg, and the patient was under observation for several days, and exhibited no objective symptoms of suffering any pain. An incision at the same point in the left leg was made, but the nerve was not found in its usual position; only a filament was found near by, which was cut, and after a further search what was believed to be the balance of the musculo cutaneous was found, closely adjoining the first filament. This was cut. At no time was the incision of the section carried deep enough to have exposed the anterior tibialis if it had been in its usual position. The wounds in this leg healed by first intention, but the patient complained of his inability to move his foot, even in the limited manner that he had previously been able to use it, and the lack of motion indicated that the anterior tibialis had been cut.

The patient's brother-in-law was a practicing physician connected with a hospital in which the staff was reputed to be very jealous of the staff and the hospital with which the surgeon who performed the operation was connected. The patient was taken to the second hospital and operated upon by the general surgeon, who laid open the leg with both longitudinal and lateral incisions, in his endeavor to find the severed ends of the nerve and to approximate these ends in an effort to re-establish function, and presumably to re-establish the pain previously suffered, which had been relieved to some extent.

The first surgeon was sued for damages, and in the trial of the suit the second surgeon testified that there was no authority for cutting a nerve for "*neuritis*," although he refused to say that the patient had ever been suffering from neuritis, and no evidence to this effect was introduced.

The plaintiff testified that he was told that there was no question but that the operation would be successful, he would be entirely relieved of his pain, and that the disability that he previously suffered would be immediately relieved as a result of the operation, and the surgeon who performed the first operation had no evidence other than his word that the statements of the patient were not true.

The witnesses for the first surgeon were the leaders of the profession in the State, and they unqualifiedly stated that the operation was properly performed, and that the result was unavoidable, in view of the malformation present at the point where the nerve was usually found, and that even though two nerves were found at the point, that it was entirely proper to cut both nerves, so long as the attempt was being made to eliminate the pain in the area supplied by the nerve which is usually found at that point in the leg.

The case was tried to the best advantage possible, and yet the jury believed the plaintiff and the quibbling surgeon who testified that it was proper to cut a nerve "*neuritis*," and rendered a verdict in favor of the plaintiff. This was appealed to the Supreme Court, and recently they handed down a decision substantially to the effect that the jury was to be permitted to pass upon all questions of fact, even though the law in this State permits a review of the evidence by the Supreme Court, even to the extent of considering the credibility of the witnesses. The Supreme Court affirmed the jury verdict, and about \$6,000.00 was paid for judgment and interest.

This experience convinces us that every surgeon should protect himself by converting his statements made to a patient to writing, and compelling the patient to sign them, if he wants to be sure that he will not be confronted with a damage suit, in which some doctor will be found who will be willing to quibble for the benefit of the claimant.

Another case in this State, in which a gas bacillus gangrene started through an opening in the skin, caused by the breaking of a bleb, or water blister, that formed at the base of the second toe after a plaster cast was applied as a splint in the treatment of a simple fracture of the tibia and fibula, at the junction of the middle and lower third. The first doctor called to attend the case requested another doctor to assist him in applying the plaster cast. The case was cared for at the man's own home. The fracture occurred when the man, who was drunk at the time, slipped on an icy sidewalk and sat down on his leg. There was no displacement of the fragments, nor laceration of tissue; in fact, the leg at the site of the fracture was not even discolored. The second doctor applied the cast over a proper mount of cotton wadding, generally used in such cases, and again visited the patient with the attending doctor, split the cast, and found it necessary to add additional padding underneath the point of the fracture to prevent a bowing backward of the tibia at that point, and closed the cast with adhesive straps. Twelve days later he was called by the attending physician, and found the leg macerated up to a point three inches below the knee. The patient, upon his order, was conveyed to a gen-

eral hospital, where in less than twelve hours following his first observing the infection, the necrosis had extended to three inches above the knee in front and to above the middle of the thigh, upon the posterior surface. The leg was then amputated through the femur, at about the center of the middle third, and the stump healed by first intention.

The examination of the leg made at the general hospital prior to the operation and after it had been removed, showed without question that this was a case of gas bacillus gangrene.

The attorney who brought the suit based his claim against the second doctor upon the contention that he was the consultant in the case, and was therefore responsible for its outcome. Counsel defended the second doctor in such a manner as would show that he was not guilty of negligence. As a result of the jury trial he obtained a verdict of not guilty rendered for the second doctor, but the jury rendered a verdict in favor of the plaintiff against the other doctor for eight thousand, one hundred and forty odd dollars. This was appealed to the Supreme Court, and recently the final decision in the case was handed down, affirming the verdict, of which \$5,000.00 and the interest thereon, was paid by the insuring company, and the balance was paid by the doctor.

We are quite sure that the other insurance company and their attorney were quite certain of having the verdict reversed by the Supreme Court, but they were unable to secure this result, even though in the trial of the case it was shown that the man was being cared for in his own home, and the directions of the attending doctor were disobeyed.

The effect of the Supreme Court decision in this case we consider to be very far-reaching and that it will impose a special burden upon the doctor who attends the ordinary case among the poorer class of people, in that the Supreme Court substantially says, when it approves this verdict, that a doctor assumes the responsibility for the conditions under which he is treating his patient, should any unforeseen or unusual condition arise by reason of conditions which the doctor is in a position to appreciate, and even though his directions for the providing of better surroundings are disregarded, there is still a responsibility resting upon him for the proper care of the patient. This holding by the Supreme Court, where up to the present time they have previously been almost unanimously holding in favor of the physician, indicates to our mind that the doctor must expect to have the rights heretofore accorded him by the decisions of the higher courts invaded from the various angles that will develop in these cases.

It is on this account that we consider that the necessity for co-operation and special attention be given to this question of malpractice, not only by us as the insurers of the doctor, but also by the doctor, and that we must build up a better appreciation among the members of the medical profession of the hazards sometimes involved in the care of what might be regarded as a simple case, and we must impress upon the doctors that the service of our Claim Department and our attorneys are always available to them whenever in their attendance of a case, there is any question as to how the case should be handled in order for them to render themselves immune from successful prosecution for malpractice damages.

PRESIDENT SPALDING: I am always glad when the question of malpractice suits is stirred up, because I had an experience with one myself once. I operated on the internal eye of a child some years ago, and I told the doctor in attendance that the internal eye was defective, and called his attention to it. He noticed it, but did not write it down, and I forgot to call the attention of the parents to it. This was a case of a turned-in eye. I operated with perfect success and the eye was perfectly straight, but they brought suit against me for somehow or other having, through the operation, damaged the eye so that its sight was now permanently injured. We proved to the court, and to the satisfaction of everybody but the jury, that in all cases where one eye turned in, the sight was defective, and that the case was a congenital one. The jury, however, found against me for damages of \$1,500. I carried the case to the Law Court, and that court decided in my favor and that there was no evidence against me, and that unless the attorney could produce further evidence that I had done something wrong at the time of the operation, they would not listen to any further trial. The case finally terminated in my going down to Machias three or four times at a large expense, and my finally turning them out of court. I got through at a cost of four or five hundred dollars for lawyers' fees and loss of my time. I did not like it. Whether it hurt my practice or not, I do not know; but I tell you I did not like to operate so much after that as I did before, because I did not know what would happen.

You know that I am intensely interested in medical defense. I believe that medical defense against malpractice suits is a mighty good thing, and should be carried out in conjunction with insurance under the insurance companies, and I am going to ask Dr. Weston if, in his experience, it would not be wise for every man in the State Association to join in medical defense, join in with the attorneys of the insurance companies, and make a better defense than they would by merely being insured in an insurance company. In other words, I claim that the presence of the President and two Councilors from the State Association would be better than the presence of an attorney alone, backed by a corporation that has got money. That is why a great many times a case goes against a doctor, for the jury think it is only against a corporation. I say, furthermore, that a safe medical hired attorney may be better trained to examine witnesses, and can do better in regard to the actual meaning of X-ray skiagraphs shown in court, than the ordinary attorney hired by a corporation, who only takes these cases sporadically; in other words, that the State Medical Association, through its regular attorney, should attend to all these cases. I believe in that

way better results would be obtained, and the lawyers could no more say to the jury: "It don't hurt the doctor, it simply hurts the corporation; and, if he has made a little mistake, we are sorry for him, but it does not cost him anything." Now, I am opposed to that doctrine, and I believe that the doctors of Maine, and everywhere else, although they should be insured, that they also ought to be backed up by the medical defense of the State Association, in co-ordination and co-operation with the attorneys of the insurance companies, as long as it can be managed.

Dr. Weston has referred to the indiscreet remarks of doctors, and I am going to tell you of an incident that happened to me not a thousand years ago. A blind man called at my office in the company of another man, and after I had examined him he asked me what I thought of his case. I told him it was hopeless. While I was in my back office—consulting room—with those two men, two women came into the front office, or reception room, to catch me making some remarks in regard to whether that case had been operated on well or not. What I said I do not know, but they wanted to claim that I had made some indiscreet remarks. Whether I did or not, the Lord only knows, for I had no recollection about it, but I tell you I was mighty glad when I found the case was nonsuited and I did not have to appear in court with this one man and two women who caught me in a trap, and who were going to swear that I had made some indiscreet remarks which led to the bringing of that suit. So I tell you that when you get a case like that you want to keep as mum as you can, especially if you do not want to have other people listening around with good ears, even if not with a dictagraph.

There is one thing that I think works badly in courts, and that is in regard to the interpretation of skiagrams. I have talked with many expert radiographers, and they tell me it is the most difficult thing in the world to tell exactly what a skiagram means, and to expect a common jury to understand them is all rot. I say that an attorney, hired by the State Association, ought to make an appeal to the court and say: "Gentlemen of the Bench, I appeal to you to make a ruling to the effect that ordinary persons can have no idea of what a skiagram means, and that no evidence shown by a skiagram in this court should have any influence whatsoever with the jury."

Now, gentlemen, I do not want to do all the talking, and I would be very glad to hear from anybody who has had any experience with malpractice suits or any suggestions in regard to this topic. It is certainly most important. You must recollect that you are going to lose your case nine times out of ten, and it costs you in your practice, and it costs you in your feelings tremendously, no matter if you do win.

DR. SAWYER: Mr. President, I am intensely interested in this paper, because it has been my misfortune, or good fortune from the results, to testify several times in malpractice suits; in fact for the past twenty-five years I think I have testified for the physician in every case that has come up in Aroostook County. I want to say further, that the party has never won one suit against a physician in Aroostook County. We have had men from the western part of the State, some of the big men, to testify against our men, but they have been thrown down every time. One case in particular I remember that was pretty near an average case—as good, and perhaps better than the most of them—and I appreciated there the discretion and judgment of our lamented Judge Haley, who, after the evidence was put in, immediately non-suited the case and threw

it out of court, and that was the end of it. Men of his stamp can sit down on a great many of these cases. I believe in every one of those cases that I testified in some indiscreet remark by the physician was what started them; perhaps not that he intended to hurt the other fellow, but wanted to show that he had a little more ability than some other chap. I think that was the notion, rather than any desire to injure the other man by the result of what he said.

This matter of insurance. Now there are two sides to that question. Of course it is a big thing for a man when he is sued to have some insurance behind him, but I know of one particular case in this State where they got a large verdict against a doctor. The presiding judge told me privately afterwards that the party got that large verdict because of the fact that the doctor had a large insurance. He said that the jury felt that the fellow was poor, he had a bad injury, a bad result, and this corporation could afford to pay. It works out that way a great many times, and still it is a hard thing for us to go along without some protection.

DR. TWITCHELL: Mr. President and Gentlemen: I confess to some embarrassment in appearing here as a singed cat, but this matter is very important, and I cannot refrain from criticising a few points that have been brought out by this paper. Do you realize how useless it would be for a plaintiff to sue a physician for malpractice if it were not for the fact that he could easily get some brother physician to testify against him? Another thing. We are very much at the mercy of the plaintiff on account of his being able to present a preponderance of evidence against us, as was mentioned in the paper by Dr. Weston. In my own case, the plaintiff's two brothers and brother-in-law all swore against me, and I had no witnesses; just my evidence against four of them. They had a preponderance of evidence. I suppose that is why the verdict in the Superior Court went against me.

Another thing which I approach with some hesitation, but which I think I ought to say. If I am correctly informed, the physician who testified against this doctor at Waterville who lost the case for the man who had the gas poisoning in his leg following amputation was the same doctor who testified against me. He has made himself conspicuous and active throughout the State in assisting attorneys to get verdicts against brother physicians, and he is a member of this Society.

PRESIDENT SPALDING: I would like to ask Dr. Sawyer if he has heard of any case in Aroostook County lately where suit was threatened, and the surgeons in the town consulted with the indiscreet doctor so that the case was broken down?

DR. SAWYER: I do not remember of the case.

PRESIDENT SPALDING: I understood that moral suasion was used with great effect in a case in Aroostook County, so that the defendant physician never had to appear in court. Are there any further remarks?

DR. SWASEY: Mr. President, I was somewhat surprised at the remarks made in relation to the value of the X-ray skiagraphs in these cases. Two years ago I had a boy with a fractured leg, just about two inches or an inch and a half above the ankle. I reduced that, as I thought, satisfactorily. I was not satisfied with it, however, and I had an X-ray taken which showed that the fracture was not in perfect apposition. The lower fracture had slipped somewhat inwardly and upwardly. I took another physician with me, gave the boy ether,

and with the application of a good deal of force we were confident that we got that bone in position, and the final result was perfectly satisfactory. Last year, a man brought a little girl four years old to my office. He had just run over her with his automobile. The left humerus was fractured about two inches below the shoulder. The femur on the right side was fractured about midway. I gave the child ether and reduced the dislocation; but I was determined I would have an X-ray of those fractures. I went to the electric light station, borrowed fifty or sixty feet of cable, and arranged to get the light. I found by the X-ray that both of the fractures were overlapped, and I had no difficulty in convincing the parents by these X-rays of the situation. On the thigh, the skiagraph, taken laterally, showed an overlapping of some three-quarters of an inch. I then made another attempt to reduce the thigh. The arm was put in this position, out this way (indicating), and we reduced that fracture without trouble. We put as much force on to the bone of the thigh as we thought we ought to, put on our splints; put on Buck's Extension. It became apparent that the little one could not stand the pelvic traction caused by the Buck's Extension, and I had another X-ray taken, and the overlapping still was half an inch. The fracture was oblique, and the lower fracture slipped above the upper one half an inch. I showed that X-ray to the father of the child, and he had no difficulty in recognizing it. I said, the only thing to do to get that in position is to take this child to the hospital, cut down on those bones, and put them in position. That seemed a good deal to him, but I told him the child's leg would be shorter if it was not done. So I took the child to the hospital, and Dr. Pingree went with me, and cut down on the bone and put it in position. I held that leg over an hour for the splint to harden, and the result was perfectly satisfactory. You would not know now which was the leg that was injured. Without the X-ray, without the skiagraph, that child would have had a short leg, and no one can tell what the result might have been for me. So I feel that the X-ray is very valuable, and that anyone of ordinary understanding can see what a fracture is and what the displacement is.

PRESIDENT SPALDING: Are there any further remarks on this important and vital question to the medical profession? If not, we shall be very glad to hear from Dr. Weston, if he has anything further to add.

DR. WESTON: In reply to the suggestion of your President regarding the co-operation of the members of your society and the profession in general with the insurance company, I might state here that our plan of insuring provides for exactly that idea. We do not accept the co-operation of men who are not members of your various county societies. One of the provisions of the policy is that no settlement can be made without the consent of three of the committee of five to whom the facts in the case have been submitted. Through that committee we seek to secure the best advice possible in the particular case. If it is a surgical case, then surgeons are brought in. If a bone case, the orthopedists are brought into that committee. The idea is this: We do not presume to be passing authority on these questions; we are seeking light; and we believe that the best place to seek light from is from the men who have had the most experience along these lines. Now, if the five men who act as a committee cannot give us any theory upon which we feel that we can successfully defend that suit, why then at least three of those men can certainly have no objection to our settling the suit, and it will be an exhibition of their best judgment in regard

to the effect that a settlement will have upon the profession in general when they do permit us to settle the suit.

Now, there is another thing that we get through this committee, and that is, we get the active co-operation and assistance of the best minds to give us the testimony upon which we can win these unjust claims. I do not expect that the members of that committee, or the members of your profession, are going to stultify themselves in an effort to defeat every claim, but if it is an unjust claim against the doctor we expect that they will interest themselves in providing the evidence upon which that claim can be defeated, and use their influence for that purpose. I have had that exemplified many times prior to originating our idea of group insurance, that is, a joining of the men of the local society together to defeat these unjust claims. We had a great many men insured under individual policies; and when we went out and asked for assistance for the man why it was usually met with this kind of a remark: "Well, John, you have got insurance?" "Yes." "By George, you are lucky. If you need me, call on." Now, that calling on includes calling them as expert witnesses. I do not care very much for expert testimony in the defense of these cases. I had very much rather have the men suggest to our attorney the questions that should be asked the witnesses for the plaintiff that will compel them, for the sake of their reputation, to testify to the truth, and if the experts will testify to the truth they will win our case for us. In the majority of the cases that we have won—and I might digress a moment and say that we have been very fortunate in that line, having had only two so far decided against us finally, out of something like one hundred that have been tried, although several are being appealed at the present time—we have won them without introducing any testimony for the defendant, the majority of them. We have won them on the evidence of the plaintiff's witnesses, and if you will assist us in seeing that our attorney gets a proper understanding of the case, and is posted so that he will ask the questions in such form as will prevent the man that is testifying for the plaintiff from quibbling, or from giving qualified answers that he knows the qualifications of and the jury cannot appreciate, why I am quite certain that we will win a good many more suits than we have won in the past.

There is another point that I would like to refer to, and that is this question of the prejudice to the doctor on account of having the verdict rendered against a corporation. It is true that there is a general idea among the most of the laity that the doctors are insured, but if the case should be tried in such a way as to disclose to the jury that there was an insurance company involved, that would mean an immediate mis-trial and reversal or remanding for a new trial. That question cannot be presented to the jury in a way where it could influence them or be permitted to influence them; in fact, a great many times the attorney trying for the defendant will egg his opponent on until he does make some statement of that kind for the purpose of forcing a mis-trial, but it absolutely has no influence except the general impression they have that men are insured.

PRESIDENT SPALDING: I think we ought to give thanks to our visitors from Massachusetts and Connecticut for their thoughtful papers. They have come a long distance to tell us what they know about these topics of interest, and I think it would be a good idea to express our thanks by a rising vote, which was done.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.**PHYSICIANS UNDER NEW DRAFT RULING.**

The following communication was received from the Council of
 National Defense :

August 12, 1918.

Subject, Enrollment of Physicians.

1. On August 8th the following statement was authorized by
 the War Department, signed by Newton D. Baker, Secretary of War :

"The War Department to-day has suspended further volunteer-
 ing and the receipt of candidates for officers' training camps from
 civil life. This suspension will remain in force until the legislation
 now pending before the Congress with regard to draft ages is disposed
 of and suitable regulations drawn up to cover the operation of the
 selective system under the new law. * * *"

Fearing that this order might be misinterpreted by doctors who
 would not distinguish between enlistment as a private soldier and
 enrollment as an officer in the Medical Reserve Corps, on August 9th
 I asked the Secretary of War to issue a statement making clear this
 point.

2. In response to this request, on August 10th the following
 statement was authorized by the War and Navy Departments :

"Orders issued by the War and Navy Departments on August
 8th suspending further volunteering and the receipt of candidates for
 officers' training camps from civil life do not apply to the enrollment
 of physicians in the Medical Reserve Corps of the Army and the

Reserve Force of the Navy. It is the desire of both departments that the enrollment of physicians should continue as actively as before so that the needs of both services may be effectively met.

(Signed) JOSEPHUS DANIELS,
Secretary of the Navy.

(Signed) NEWTON D. BAKER,
Secretary of War."

3. It is desirable that the definite attention of the medical profession be called to this interpretation in order that enrollment for the Medical Reserve Corps of the Army and the Reserve Force of the Navy, which is going on so rapidly at the present time, shall not be interrupted. Trusting that you will give this prominent space in the next issue of your JOURNAL and such editorial comment as you may deem desirable, I am,

Yours very truly,

FRANKLIN MARTIN,
Chairman General Medical Board.

THAT POOR EXCUSE, A LIEUTENANT'S PAY.

Many available physicians are refusing to volunteer to help the nation in its dire need on the plea that they cannot afford to give up their practice and leave their families unsuitably provided for on the pay of a lieutenant. A note from Major Green, in a late number of the *Journal of the American Medical Association*, effectively exposes this fallacious excuse by proving that a maximum of fifty dollars a month will cover all possible costs for the maintenance of a lieutenant except those due to extravagances in the way of dear cigars, high living and costly uniforms. A lieutenant with a fifty-dollar maximum a month can give the rest of his pay to his wife, whom he will find will, with a woman's wise economy, make both ends meet. If not, she will make sacrifices and not complain, as he is now complaining and making excuses. Do let us have an end to this monetary excuse. We wonder how many of us think that the officers of the English, French, Italian and others of our allies get less than half of our officers' pay, and that their wives and families get along by sacrificing for the common cause. If those who put their minds on inventing excuses for not going would simply think of why they ought to go, the quotas everywhere would soon be filled.

So, too, if physicians who think themselves "essential" to a civilian population, to a hospital staff or to a medical school would only open their eyes and take a look at the shadows of former great

physicians, who thought that they, too, were "essential," yet in due time died and their places were amply filled; we say that if they would only think thus, they would see that nobody is "essential" in this world of change. If they were, where would there ever be a chance for any young man to do anything except to rust his life away in the book learning of the schools. This is a world of change, constant change, and with its changes every human being must move along, do his duty as he moves, and take his chances for the future with all the rest of humanity.

WHAT YOU ARE MISSING.

We have received from a base hospital somewhere a letter from one of the able physicians of this country, who volunteered at the beginning of the war to help out our soldiers. And from that letter we quote two or three sentences, in substance, which show in a vivid light just what good this work is doing for the physicians, to say nothing of its contribution to the national cause.

"If our men could only realize what they are missing by not volunteering at once they would not hesitate for an instant, but come forward now and work to the best of their ability for the soldiers and the nation in its need for their services. As I look back a year over the wonderful experiences which the army furnishes, it seems to me as if I never did anything at all worth while in my civil practice, where we worked and talked small figures. Ten patients a day was then a good many, 100 in all a large number to handle in a month. But now we use big figures, 150 men in an hour, 1,000 in a single day, and in five weeks one of us looked over a division of 30,000 men. But this work is only one small part of the broadening influence of army life. Twice a week we have medical officers' meetings, in which we have presented to us all phases of medical subjects, and we have additionally that unique personal experience of meeting many line officers from all parts of the country.

"You men at home are just marking time, waiting for something to turn up, but here we are never marking time, but steadily marching ahead at a double quick pace, and something new is turning up every minute of the working day. Here is a list of what we have heard discussed at meetings in the last two weeks: 'Tuberculosis in the Army,' 'War Neuroses,' 'Abdominal Surgery,' 'Aviator Tests,' 'Pneumonia,' 'Gastric Ulcer,' 'Meningitis,' 'Carrel-Dakin Method,' 'Gases in War,' and wonderful slides of actual hospital treatment and operations abroad have been shown."

Think these points over, you men remaining still in civil prac-

tice; stop inventing excuses for staying at home; put your minds solidly on this one focus, why I ought to go. Is there really and truly any medical practice for any patient that some other man cannot do fully as well as you? Is there any hospital appointment that some other man cannot fill as well as you? Are you the only man left who can teach medical students what they need for the practice of medicine and surgery? Look at the war from that point of view, and let some older man do your work for you until you have accomplished your duty to a greater population than in any city in which you are practicing, or in any hospital, or in any medical school.

J. A. S.

THE EDMONDS BILL FOR ESTABLISHING A PHARMACEUTICAL CORPS IN THE MEDICAL DEPARTMENT OF THE UNITED STATES ARMY.

A year ago last July, July 25, 1917, Mr. Edmonds introduced a bill as above entitled, the idea being to establish an Army Pharmaceutical Corps, who should be charged with the following duties: To buy or manufacture all medicines, drugs, chemicals, pharmaceutical apparatus and hospital and surgical dressings; to determine their quality and purity; to take charge of such supplies; to provide for their issuance; to look out for all spirituous liquors and habit-forming drugs, chemical reagents and biological products used in laboratories; to inspect supplies of drugs, dressings and reagents and to determine if in any way deteriorated; to join in with other branches in first aid and in making tests, and to establish and maintain a systematic course of study and training in all of the topics and subjects before mentioned.

The department is to be in charge of a pharmaceutical director with the rank of major, five deputy directors with the rank of lieutenant, and of such apprentices as may be needed for carrying on the provisions of the bill.

We are asked to give the support of the JOURNAL to the proposed Edmonds bill, which has so long hung undetermined in Congress, and this we gladly do, for we recognize the need of such a department as here so briefly outlined. We trust that our members will do what they can to forward the proposed bill, and at all events to give its provisions a careful and thorough study, with a view of deciding upon its value and furthering its provisions. The bill is referred to as the Edmonds bill, H. R. 5531, 65th Congress, First Session, and in mentioning it to our Senators or Representatives this identification will suffice to move along a very promising bill.

J. A. S.

MAINE'S FEEBLE MINDED.

We wish to remind the physicians of the State of the circulars sent out by Dr. Fernald, under direction of the Governor, regarding the feeble minded. These people are defined as those who, by reason of innate or lifelong defect in intelligence, or deviation of character, are but partially self-supporting, and to some extent dependent for guidance and maintenance. The insane, the majority of epileptics, the demented, and those children who may become self-supporting by training, are not of the feeble minded. All others, as above defined, need to be classed together, and physicians ought to do their share of the good work by discovering them, and after naming them on the appropriate blanks furnished by the State forward their information to the Maine Commission for the study of feeble mindedness at Augusta.

NON-SPECIFIC ARTHRITIS FROM GENITO-URINARY INFECTIONS.

We print elsewhere a paper by Dr. Peters, which, though all too brief, brings forward for our consideration another new possibility of causation in obscure cases of arthritis. As the writer remarks, a good deal and perhaps over-much attention has been paid to the condition of the teeth as the *ultima thule* of all infections of the body corporate, but it is time, as we will all agree, when the teeth have been thoroughly overhauled, removed or put into good shape, to look elsewhere for the infection in doubtful cases of arthritis. The cases appended go to prove, without over-exaggeration, that those who claim a genito-urinary infection in a certain percentage of instances have a perfect right to state their beliefs forcibly, and with satisfaction to themselves and their readers. It is pleasant to the editors of the JOURNAL to have papers of this sort handed in by the younger members of the profession, because they show a desire to do their work well and to bring it forward for medical and surgical consideration. A new paper, a new name, added to the list of the JOURNAL's contributors cheers the mind of the man in charge, often overworked to find suggestive material for each monthly issue. Many physicians could contribute to our mutual improvement by interchange of thought and experiences as briefly brought forward in this promising paper.

CONSERVATION OF VISION.

We are glad to note that the State Board of Health intends to take up the very important topic of "Conservation of Vision," and to discuss the best methods of bringing it before the people, at a meet-

ing to be held early in September. The mere exhibition of slides, similar to those shown by the retiring President at the June meeting, would give the people a very distinct idea of the enormous value of this highly valuable health question. We shall hope to know ere long that plans have been formulated, and once done we are sure that our competent State Board of Health, with the Commissioner, Dr. Bristol, and his competent assistants, will carry it out to the perfect satisfaction of all concerned. Every school child in Maine ought to have made plain the dangers of infants' sore eyes, carelessness in handling tools and playthings, and the need of getting properly fitted lenses from men alone who are competent to do the work as it should be done, scientifically, and not by mere slipshod guesswork at grotesquely absurd prices for poorly fitting lenses and frames.

THE LABORATORY THAT KNOWS HOW.

The Cutter Laboratory of Berkeley, Cal., has for twenty years been serving the physicians of the country; but in order to better meet the requirements of the profession, they have reorganized and enlarged their Chicago office, and are better prepared than ever before to serve the interests of our readers. Accordingly this JOURNAL has accepted their page announcement and is printing that announcement in this issue. If you find their service available for your practice, we bespeak for the Cutter Laboratory a share of your patronage.

County News and Notes.

KENNEBEC.

KENNEBEC COUNTY MEDICAL ASSOCIATION.

Thursday, August 1st, the Kennebec County Medical Association was the guest of the Fairfield Sanatorium, Fairfield, Maine, where the quarterly meeting was held jointly with the Somerset, Waldo and Franklin County Associations. The business meeting was held at 5.00 P. M., followed by supper at 6.00.

Dr. George H. Coombs, of Waldoboro, President of the Maine Medical Association, was present and spoke at some length on the plans of the Council of National Defense for enrolling physicians into classes, namely, those who are enrolled in the Medical Reserve Corps and those who will be enrolled in the Voluntary Service Corps for service at such parts of the United States as the exigencies of the civil population seem to demand. He also outlined the work of the Committee on Health Centers, recently appointed by Governor Milliken.

A paper on "Sub-Acromial Bursitis" with Observations on Other Types of Disabled Shoulders," was given by Dr. Hilbert F. Day, of Boston, Surgeon-in-Chief to the Boston Dispensary.

S. J. BEACH, *Sec.*

YORK.

YORK COUNTY MEDICAL SOCIETY MEETING.

The ninety-third quarterly meeting of the York County Medical Society was held at the Parker House, Kennebunkport, Thursday, June 27th. It proved to be a good day and a very profitable meeting in all respects. An excellent dinner was served at one o'clock. None of the officers being present, owing to imperative medical reasons, Dr. G. H. Coombs, President of the Maine Medical Association, called the meeting to order at 2.00. Dr. E. C. Cook, of York Village, was elected chairman, and Dr. H. L. Smith, of Kennebunkport, Secretary *pro tem.* Dr. Coombs read a paper on "The Need of the Hour for the Medical Man," in which, as can be seen from the copy printed elsewhere, he made a strong plea for volunteering for the medical service, and outlined a plan for enrollment of all physicians either in the Medical Reserve Corps or in the Volunteer Medical Service Corps.

Dr. F. W. Lamb, of Portland, followed with an interesting and instructive talk in relation to the X-ray in the diagnosis of diseases of the stomach and the intestines, and illustrated his points with excellent skiagrams. A well-considered address on "Public Health Service in York County, Maine, and Rockingham County, New Hampshire, with the



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The grains come out as toasted bubbles, puffed to eight times normal size. They are thin and crisp and savory — fascinating foods.

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Each 15c Except in Far West

(1943)

U. S. Navy Yard at Kittery as a Center," was given by Dr. Clifford E. Waller, U. S. P. H. S. Valuable case reports were made by Drs. O'Neill, Marshall, Brown and Smith, and were widely commented upon and discussed by all present. The chief topics thus discussed were "Poisoning by Bi-Chloride" and "Vomiting of Pregnancy." This was a welcome feature of the meeting.

The meeting was unusually successful and was attended by some thirty members and their wives. Amongst those present we noted Dr. G. H. Coombs, Waldoboro; Dr. and Mrs. F. W. Lamb, Portland; Dr. and Mrs. H. A. Owen, Bar Mills; Dr. and Mrs. W. H. Barker, West Buxton; Dr. and Mrs. E. C. Cook, Dr. and Mrs. F. W. Smith, York Village; Dr. and Mrs. S. B. Marshall, Alfred; Dr. L. H. Brown and Miss Brown, Dr. and Mrs. J. O. McCarrison, North Berwick; Dr. and Mrs. E. D. O'Neill, Dr. H. M. Ferguson, Biddeford; Dr. and Mrs. W. W. Smith, Ogunquit; Dr. H. P. Ilsley, Limington; Dr. Guy Hinsdale, Dr. K. B. Tracy and Dr. and Mrs. W. L. Prescott, Kennebunkport.

H. L. PRESCOTT,
Secretary pro tem.

REMARKS BY PRES. COOMBS OF STATE ASSOCIATION.

For the needs of the war the doctors of the State of Maine have been further asked to respond by way of one hundred additional volunteers to the Medical Reserve Corps, and to this end, in order to carry on the work quickly, a committee was named to enroll these medical men. Waiting for some necessary data from Washington before active work in this direction, the meeting of the York County Medical Society at this time is one which cannot be neglected, and it is a privilege to be an humble agent in calling your attention to this most vital need and to the great opportunity which more insistently than ever before confronts us all as members of that profession whose work is ever one of sacrifice and ever for the relief of the ills of humanity.

The survey of the enrollment in this corps, published in the *Journal of the American Medical Association* for June 1st, shows that, with a physician for each nine square miles of territory and a population of 71,000, York County had 107 physicians, of whom nine had entered the service, leaving, in order to equal the minimum hopes of the War Department, a call for twelve more to enroll.

That this need will be filled everyone believes. It should not be necessary for direct solicitation of any doctor in the State of Maine. We cannot decide this thing in a meeting. We must again take it home, talk it over with those who will be most affected by the separa-

tion—for those who must remain are the ones hardest hit—and looking the matter fairly in the face make the only decision possible, namely, that only questions of dependence and immediate, insistent financial stress can call for negative answer.

To no other class of men in the world is given this great privilege of relief work, and it is hardly needful to say that no others can and will respond so strongly to the call.

The new act of Congress gives additional commutation for quarters to married officers, so that lieutenants get \$432.00 extra for family if no quarters are available. This is a marked relief from stress of finances.

A second committee has been named whose duties are to enroll other doctors (who, being over the age of 55 or from disabilities, are rendered ineligible for the Reserve Corps, or because of some dependency or duty of public nature) into a body known as the Volunteer Medical Service Corps. The object of this corps shall be to establish an emergency medical organization to perform, when required, such civic and military duties as are not provided for.

The boys over there are calling us. We see them entrain for camps, we wish them Godspeed, but one and all, I believe, we are not satisfied. It seems to me that each of us should often ask himself the question, "Am I doing my part in the burden of this war?" Can I look these boys in the face when they come home and be ready for the query, "What did you do?" or must I take a side street and leave to them and theirs the honest pride in making this world again a safe one for the children, for the mother, the wife, the sweetheart?



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Pettijohn's Flour — 75 per cent Government Standard flour with 25 per cent bran flakes. Use like Graham flour in any recipe.

Both sold in packages only.

(1938)

We have a duty to those who have gone and who will go, not alone that we see to it that their loved ones are cared for, but that when they return every bit of the prestige they have worked for before going is theirs in the reopening of their work here.. Upon the manner in which those who must needs stay at home meet these tests will rest the hopes, the courage and the faith of the volunteers and their dependents.

PERSONAL NEWS AND NOTES.

Major W. E. Kershner, M. R. C., Bath, has just printed, in the *American Journal of Ophthalmology* for July, an excellent paper on the causes of an epidemic of twelve hundred cases of acute conjunctivitis at Camp Sherman in the winter of 1917-18.

We regret to announce the death, from meningitis, at Fort Oglethorpe, Georgia, June 11th, of Lieut. William Edward Emery, M. R. C., of Bangor.

Late letters from Italy inform us that Dr. and Mrs. Witherle are housekeeping at Fiesole, Italy, a hill town in the delightful suburbs of Florence. Both remain in good health, but are making no plans to return home until after the war.

DINNER TO DR. ROBERT ABBE AT BIDDEFORD POOL.

A very delightful dinner was given on Friday, June 21st, at the Tea Rooms of Mrs. Brown at Biddeford Pool, by the staff of the Webber Hospital, of Biddeford, and the physicians of Biddeford and Saco, as well as of a number from Portland, on an occasion to meet Dr. Robert Abbe, of New York, who was on that date in the vicinity and operated on a patient in the hospital. Some thirty physicians in all attended, together with the entire staff of nurses of the Webber Hospital. After partaking of the most delicious and very well served menu, after-dinner speaking on a moderate scale followed, the speakers being felicitously introduced by Dr. Cochrane, of Saco. Remarks were made by Dr. John F. Thompson, Dr. H. H. Brock and Dr. Spalding, of Portland, whilst the speech of honor fell to Dr. Abbe, who carried it out with great success and satisfaction to all concerned. Rarely have we attended a more interesting entertainment, one to make its mark in the history of the good work of the staff and nurses of the Webber Hospital and the physicians of Saco and Biddeford.

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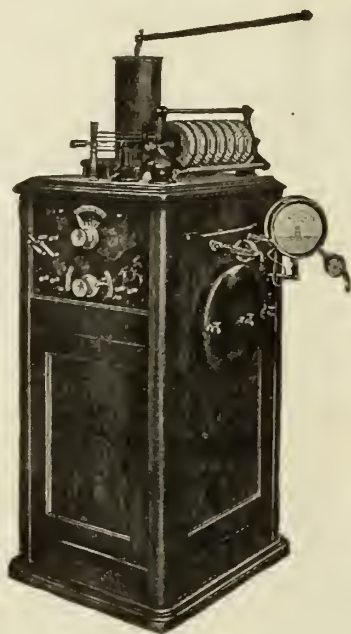
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NO. 2

HEALTH INSURANCE.

BY FRANK E. ROWE, M. D., AUGUSTA, MAINE.

The honor and the opportunity of addressing this association on an important subject suggested by our honored president, is deeply appreciated.

The health insurance scheme originated in Germany in 1883, becoming compulsory in that year. Before that time there were many societies insuring members, and about one-half of those for whom the law was intended availed themselves of the voluntary form of insurance. At first there was no attempt to centralize control.

Austria followed closely Germany's plan. Previous to this, Austria had large funds and voluntary organizations. In both Germany and Austria it is obligatory on the employer to enforce payments of the working men. If the workman does not already belong to a society he must join at once or be fined or imprisoned.

The compulsory form of insurance was put in operation in Norway in 1909; in England, 1911, and in Switzerland and Russia in 1912. In Denmark, Belgium and France there are many insurance societies. In France in 1905 there were 11,000 societies and over 1,700,000 members, showing that under voluntary insurance many availed themselves of the opportunity to insure. Switzerland probably had the best law of this type.

In Germany various methods are used in complying with the law. The minimum benefits provided by the sickness insurance system consists of medical attendance, medicines and supplies from the date the sickness or disability begins, regardless of whether it causes inability

to continue working. If the sickness or disability prevents the insured workman from continuing his work, he must be granted a pecuniary benefit which must not be less than one-half the rate of wages paid in the locality for unskilled day-labor. This benefit begins on the fourth day of disability, and is to be paid not less than twenty-six weeks. A benefit of the same amount is paid for six weeks after the date of confinement in a female-insured person in case of childbirth. A financial benefit is also included as a rule. A person included in both sickness and invalidity insurance, who is disabled by sickness, receives the regular sick benefit for a period of twenty-six weeks.

The services of a physician are provided for in accordance with the regulations established by each fund. The usual plan is for the fund to make a contract with a number of physicians who give their services in return for an annual sum, fixed in advance, or for a specified sum for a patient, also fixed in advance.

In Leipzig there may be a capitation fund of a stated amount, divided according to services rendered to each patient, each medical service rendered counting so many points; that is, a day visit one point, and a night visit two points, etc. In this city the patient has the right to choose his physician from many on the panel. Eighty per cent. of the physicians of the city are on the panel. Some of the funds, in order to secure the thorough competition and low rates from physicians, provide only the services of a limited number of physicians. This has caused a great deal of difficulty between the physicians and the funds. There are a great many rules and regulations necessary, and though the doctors are vitally affected by the law, the control is largely in the hands of laymen.

In 1911 the combined local sickness funds at Leipzig, Dresden and Stuttgart, with an aggregate membership of 412,000, paid \$1.82 per member for general treatment by general practitioner and specialists, exclusive of dental treatment. Several other important funds paid separate fees for attendance on dependents, the mean rate being \$2.06 per family, exclusive of the insured head of the family. If we assume that the average is three dependents per family, the cost per individual would be 68 cents. Under the capitation method the specialists were paid \$1.62, or \$2.50 for each case, the treatment to continue six months if necessary, these cases being referred to them by the general practitioner. The general practitioner is paid \$1.00 each for single members, \$1.75 for married members, and the pretentious sum of \$3.50 for confinements; night visits \$1.99, and night consultations 50 cents. The specialists are paid the minimum fees of the Prussian official scale.

In Essen in 1911 the local sickness societies paid physicians at the rate of 25 cents for a consultation and 31 cents for a visit. At the present time the pooled capitation payment is now 81 cents for the general practitioner, and 1.2 cents for the specialists. So the detailed cost of medical treatment was \$1.29 a head, and the cost of hospital and other treatment, \$2.22.

In Dresden a fixed salary is paid the physicians and all the appointed physicians engaged in private practice to some extent. The salaries range from \$150 a year to \$1,250, and the only extra payments are for night visits of 75 cents and mileage, in the case of rural doctors.

In Munich medical attendance is provided for twenty-six weeks, exclusive of drugs and hospital treatment. In this city office visits are considered to be worth 18 cents.

In Austria the insurance is patterned largely after the German plan. The employer is required to force payments of the working men. The insurance system is less developed in Austria than in Germany.

Health insurance was adopted in Great Britain in 1911, and as you all know, led to a great deal of trouble between the medical profession and the government. It was even necessary for the doctors to strike. Under this law it is compulsory for all employed persons between the ages of 16 and 70, excepting those in the employ of the government, these people being provided for under other acts. People not provided for under the insurance act, may voluntarily insure.

The doctors' fees are correspondingly low. A great many doctors refused to go on the panel at first, but were later obliged to do so in order to make a living and support their families.

The insurance system in England is not a success, though some of the paid officers of the government contend that it is. Some time ago an undated and unsigned statement was published by the British Medical Association. This statement is of no value, and it was no doubt written by some salaried doctor in the employ of the government.

A number of noted Englishmen and many physicians state that health insurance is not a success in England. One noted retired official in particular, states that the large number of poor who have the greatest need of assistance, were not receiving the benefits. Another states that in taking over the incomes of the doctors and re-distributing them, the meanest thing has been done by Parliament since the days of Charles the Second.

At a medical meeting held in Germany in 1917, 25,800 physicians went on record as opposed to medicine becoming a state department;

agreeing that medicine is best practiced when the doctor can treat the sick as a free and independent consultant.

Compulsory health insurance was first agitated in this country about four years ago, and has been before the public for the past two years or more. The agitation was started by the American Association for Labor Legislation. They have provided what they call a model bill, and have tried to introduce it in several legislations, and although it has been rejected, they have been persistent in their efforts in the same direction. This bill specifies that all people working for wages and receiving a salary of \$100 a month or less should be insured, and provides for voluntary insurance for self-employed persons who were not receiving a salary of \$100 a month on an average; that it should be compulsory on the basis of joint contributions of employer, employee and state. It provides for a specified period of illness or disability, this period being twenty-six weeks.

There is no demand for any change in our present methods of treating the sick. The American people have not asked for any laws patterned after those in Germany, but this society claims all kinds of advantages for health insurance. They claim that poverty is caused by disease, and state that compulsory insurance is a great success in all countries in which it is in operation, and because it is such a success it should be immediately put in operation in this country. They claim that it is a success in all countries, while as a matter of fact it has only been in operation a short time in England, Russia and Switzerland.

The members of this society make the most unreasonable statements concerning insurance and go so far as to say that it will come to the United States, and it certainly will come if they can possibly force their views on the people. Why are they so persistent? The motives of this society can well be questioned, though some of the members may be acting in good faith, no doubt.

I have thought for some time that this health-insurance menace was of German origin, and recently some of the California writers expressed the same opinion. It is now a well-known fact that Germany has been preparing for this war for many years; that the Kaiser encouraged the exchange of college professors between American and German universities and colleges; that he also encouraged musicians and other talented people to come to this country, and in every way tried to spread German "kultur" in America.

Even though health insurance was a success in Germany and England, that would be no reason why it should be introduced in America. It has not been introduced in France. In France they have many voluntary insurance societies and compulsory old-age insurance.

The working people in the countries having compulsory insurance are the poorest-paid laborers in the world. This is notably so in England and Germany. Ex-Ambassador Gerard states that the working men in Germany probably work longer and get less out of life than any working men in the world: that laws made ostensibly for their protection, such as insurance against unemployment, sickness, injury, old age, etc., are in reality skillful measures which bind them to the soil as effectively as serfs of the middle ages were bound to their masters' estates: that a skillful workman in Germany receives less than \$2.00 a day, for which he has to work at least ten hours: that Germans are taken care of and educated in very much the same way as the authorities here look out for the inmates of a poor house or penitentiary; that in Germany women do much of the work done here by men, the pay ranging from 20 cents to 48 cents a day. Over 55 per cent. of the families in Berlin are living in one room. Mr. Gerard says this form of insurance was devised to meet the discontent due to long hours and low wages prevalent in the larger cities in Germany: that these provisions have so dulled the sensibilities of the German people and destroyed the initiative and self-reliance to such an extent as to encourage the growth of autocracy and caste control.

Under compulsory health insurance, the doctors are continually called on to treat trivial ailments, and thus are obliged to neglect the study and treatment of serious cases. There are also thousands of cases of malingering with which the officers and the doctors have to deal.

Let us see what would be the result of health insurance if established in this country:

First, it would divide the people into two classes—those considered able to care for themselves. Second, those unable to properly look out for themselves: therefore the state must come in and care for them. The division is based on wage-earning capacity. Third, it divides the medical profession into two classes—those doctors on the panel and those not on the panel.

The proposition is un-American and against all of our ideals. It will create class-distinction in this country, and even if it were feasible it would seem that it was against the constitution of the United States, as it discriminates against a large number of our people and against the medical profession. These reformers and agitators say the profession is not discriminated against, for the reason that they do not have to go on the panel unless they wish. The majority of the doctors would be compelled to go on the panel because most of their patients would be affected by the law.

They have even suggested that the doctor be limited as to the number of insured persons or families that he may have on his list, thus directly limiting his income. They seem to forget that this is the United States and not Prussia and that the limitation of the incomes of individuals and members of professions is a new proposition and has no place among the laws of any republic. Under this system the doctors' income would be very much reduced. He would have to work very hard devoting his time largely in treating minor ailments and giving him no time to treat serious cases. He would have troublesome records to keep, there would be no end of red tape, and he would be interfered with continually by officials and politicians; the personal relationship between the patient and physician would be destroyed; also all incentive for medical research, and make a dissatisfied profession.

We have better health laws and agencies than in any other country in the world. The members of the medical profession of the United States are not ready to join the politicians and work for so much per day, or sell their services to an insurance fund. The profession as a whole has been opposed to lodge practice, and they are now confronted with something of a similar nature but very much worse. The members of this society and their employees tell us that there are many members of the profession in the large cities, such as New York and Chicago, who are not making a living. This is no doubt so, as there is an over-crowding of the profession in some of the large cities. There are many towns throughout the United States in which there is no physician in active practice, and doctors practicing in such cities would be able to build up a fair practice in a short time, should they settle in these towns.

The war has made big gaps in the profession, especially in Europe, and there is likely to be a universal shortage of doctors after the war. The profession should see to it that the men in the service do not return to find their practice gone and medicine controlled by politicians and a few swivel-chair doctors in their employ.

The moral injury done the people living under this law is past computation. It lessens public ideals of honesty and destroys the spirit of personal independence. A law of this kind would be a blow to pride and would result in the destruction of an element strong in the progress and achievement of the nation. It substitutes compulsion for voluntary thrift, and would humiliate a very large class of wage-earners, who are not only willing but anxious to care for themselves.

From the earliest times the medical profession of America has given freely its time and attention to the poor and needy. Thousands of dispensaries and hospitals have been established throughout the

country, and hundreds of doctors give their time to these institutions, and there is hardly a physician to be found but what does some charity work during the year. No man does more for his fellow-men than the physician. From time immemorial there have been three learned professions—law, medicine and theology, and there is certainly no profession more important than medicine.

The members of the medical profession cannot be handicapped and regulated by laws that to a marked extent reduce their income, and what is most important, lower their social standing. Every young medical man begins his professional career with the hope that he may accomplish much in his chosen profession. If that hope is limited, enthusiasm will die and he will lose interest in his work, all to the detriment of his patients. Eventually, this lack of enthusiasm would bring about the collapse of the insurance scheme, if established.

Members of a learned profession, such as medicine, cannot be reduced to the ranks of tradesmen, and be satisfied. The element of pride is strong among the best men in the profession, and this is no small factor to be considered. These exponents of the Kaiser's insurance scheme ignore these features intentionally or otherwise. The medical service obtained from a profession whose income and social standing have been reduced by their government would be poor, indeed. Every avenue of advancement would be closed to the struggling practitioner, his income would be less than many of his patients who would be independent, and they could put the money they now pay out for medical attention in the bank, or use it towards an automobile fund.

Has it not seemed strange to you, fellow-practitioners, that this society should come forward and try to establish laws in this country? Why are they advocating measures never demanded by the beneficiaries to be, and absolutely unknown to the majority of the people and to many physicians? Why are they taking such a sudden interest in the welfare of the public; in the welfare of one part of the public at the expense and detriment of another? Be assured, that it is not love for the common people that leads them to agitate such a measure. They do not seem to be interested in the doctors, as the bills thus far presented would ruin the American branch of the profession in the same way as it has been accomplished in Germany, Austria and England. The time has come for the profession to take a more definite stand and endeavor to protect the public and themselves from this European parasite, which is called "health insurance."

The scheme was advocated in this country at about the time of the beginning of the present war, and as I said before, I feel that the whole project is of German origin. The professional social worker

attached to the propaganda of compulsory health insurance would naturally favor it in the same way as a lawyer labors for the client he represents without reference to the merits of the case. Advocates of the insurance scheme say some of the physicians are in favor of it, but the doctors they mention do not represent the general medical profession, but are men who have had absolutely no experience in general practice, or specialists who have been so long out of general practice that they are not in touch with general medicine.

The health insurance experiment would be made at the expense of the medical profession. A layman should have the same right to expect the state to provide legal services at a cut rate as he has to demand medical treatment.

A committee on social insurance was appointed by the American Medical Association. The executive secretary of this committee has been an agitator of this form of insurance for years, and has written a great deal on the subject. The committee at first seemed to accept it as a fact that health insurance would some day appear in this country, but it now seems that they are experiencing a change of mind. Though the association has done much for the profession of America and the people as well, it has now the opportunity of taking the lead and fighting the propaganda which will ruin the profession, provide inefficient treatment for the people, and pave the way for other laws which would enslave the people in this country as they are in Germany and Austria.

The American Association for Labor Legislation is really not an American organization. It is affiliated with a number of organizations of similar character in foreign countries. It is an international affair, and is not composed of either doctors, employers or employees. This society claims many things for health insurance, and says we might as well begin to arrange our affairs to accommodate it. The A. M. A. committee has published a number of pamphlets concerning the subject, but strange to say, have not said anything about the effect of such a law on the medical colleges and the medical students of the future.

The committee on education of the American Medical Association has done a great deal toward raising the standard of medical education in America. They have inspected the medical colleges several times, have classified them, and have caused many of the poorer-equipped colleges to close.

In 1904 there were 28,142 students in the medical colleges of this country; in 1914 there were 16,502 students studying medicine; in 1904 there were 5,747 graduates; in 1914, 3,594 graduates, and 3,379 in 1917. Thus, we have had a great reduction in the number of men studying medicine; also in the number of graduates. The preliminary

requirements have been increased considerably, so that now our medical colleges are not outranked by those of any other country.

Great advances have been made in all branches of medicine during the past few years, and fewer men have been going abroad for study each year.

The American surgeons are the leaders in all branches of surgery with the exception, perhaps, of military surgery. The surgeons of the Allied countries have naturally become more proficient in this branch during the war.

If this health insurance scheme was introduced in America to any extent, it would cause many medical colleges to close. What young man would spend four years in High School, two years in academic college work, four years in the study of medicine, and perhaps one or two years in a general hospital in order to practice medicine under this law? The length of time required, the cost, and the small remuneration would cause him to choose some other profession or vocation. The ordinary, ambitious young man of a good family could not be hired to study medicine. After ascertaining the amount of fees, and learning of the conditions under which doctors would work, he would not consider the medical profession at all.

The population of America has increased very fast during the past ten years, and in a short time, under present conditions, there will be a great shortage of doctors in some communities.

This crowd of socialists and reformers tell us that the man who draws a salary of \$100 a month is poor; that the state and employer must step in and force him to pay over a certain amount to the state in order that he and his family may have suitable medical attention when ill. Nowhere has the greed of the socialist been more exposed than in trying to force such a law on the people and in attempting to ruin the most unselfish profession in the world. They try to make the physician believe that he will benefit under this law and try to get him to support the scheme which will mean his social and financial ruin. He is assured it will be to his advantage to do for 50 cents what he now does for \$1.50 or more.

These uplifters working for a salary seek to put the medical profession in a position of utter helplessness. Thus, the uplifter will have a share in the graft and be the main factor in the management of the sick, and the doctor his dependent.

The socialistic element is very strong, indeed, and some members of the society or their representatives have been forced to admit that the doctor would be much worse off under the provisions of the bill they advocate.

Politicians are easily attracted by any law that involves the spending of public money, and some of them, no doubt, have been able to see in this scheme the means of largely increasing their revenue.

The estimated cost of maintaining this health insurance scheme would be enormous in any state, and people who do not come under the provisions of the law would be taxed to maintain a very expensive system, and the people who are the least able to pay for medical attention would not be benefited at all under this law. The majority of the people who would be compelled to be insured under the law are in most instances people who are fully able to pay the regular medical fees.

The great middle class of people taken as a whole during ordinary times, not only pay their bills, but accumulate money. These people deposit in the banks annually millions of dollars, own automobiles, and enjoy other luxuries.

Many classes of labor, especially railroad workers, are highly paid, and it has been found that families having an income of \$800.00 a year have been able to accumulate money.

In Massachusetts one family in every three lives in its own home, and like conditions of thrift prevail all over the United States.

In Berlin 55 per cent. of the families are families living in one room, while in America wage-earners have on an average of four rooms to each family. This shows one difference between conditions abroad and in America.

These agitators contend that sickness is the cause of poverty. This is not so, as poverty is the cause of illness in a great many cases. Less than three per cent. loss in America is from sickness by actual statistics. This does not argue that sickness is the cause of poverty.

Most of the insurance systems make no provisions whatever for chronic ailments, such as tuberculosis, mental diseases, carcinoma, or diseases extending over a long period. It is a poor family, indeed, that cannot pay their doctor during a short period of illness. It is a long, continued illness in a poor family that would help to reduce them to poverty, but in such a case the real cause is insufficient wages, alcohol, or shiftlessness on the part of the wage-earners in the family.

With such a system in operation the state institutions would still have to be maintained; the overseers of the poor and the State Board of Charities, the dispensaries and clinics would still be doing the same work at the same expense.

Health insurance would not lessen poverty, as only a small part of it is due to sickness. This scheme would only be palliative. The people whom compulsory insurance is designed to help are already in

a position to avail themselves of medical service; also to indemnify themselves through voluntary insurance if they so desire. Compulsory insurance does not rectify the unsanitary conditions under which people live. Given a decent place to live in and fair wages, a workingman can pay all medical charges as well as other bills. There is no reason why he or his family should get medical attention at cut rates. Why not make a law which specifies that grocers, butchers and coal dealers may make only a small profit, for to these people goes the most of the money the working man pays out? No. This combination of socialists and uplifters have determined to debase the American medical profession. They feel very keenly the hardships of the poor fellow making only \$100.00 a month. They find that he cannot pay his bills like an independent citizen. He must be protected against the doctors and given medical attention at a greatly reduced rate. Though he has money for automobiles, his medical attention must cost him less than his beer and cigars.

We are told that health insurance is all in the direction of preventative medicine and in accord with modern progress. They say that the public gets better attention from the indifferent and poorly-paid contract doctor who has absolutely nothing to look forward to. Under such a law there would be no advancement for the practitioner. He would treat the head of the house and other members of the family for an insignificant fee, and sit up nights and attend the mother when she is confined for a sum less than a nurse receives per day. The specialists would not escape, as clinics would be established where they could give advice at the rate of one dollar or less a consultation.

Extensive studies have been made by the committees of the Illinois Medical Society and the Chicago Medical Society. The Chicago Medical Society, the largest local medical society in the world, at a meeting scheduled a health insurance program giving 6,000 doctors a chance to express their convictions, but the compulsory insurance advocates could not get a single physician who had practiced under the act in the countries of Europe to appear on the program in favor of the scheme, and the medical society could not get a single European physician to admit that the scheme would benefit the profession, or even better the treatment of the working masses. Another society reports that the fundamental needs of the poor are want of sufficient wages, want of nourishment, want of warm clothing, want of decent housing and want of rest. It has proven that in 1905 there was more money spent for alcoholic drinks than for groceries and meats in the city of Chicago alone. In Kansas, where prohibition has worked out the most effectively of any of the states, poverty has almost vanished.

Kansas now has the lowest death rate and the largest amount of money per capita of any state in the union.

In Germany the average number of days of sickness for each member increased from 16.2 in 1890, to 20.2 in 1913. There is also an increase in Austria, but not as marked an increase. In 1912 the death rate in Germany was 15.6 per thousand population; in Austria 20.5. In Australia the same year the death rate was 11.2; in New Zealand 8.9; Denmark 13, and Sweden 14.2. The last four countries have no compulsory insurance laws. The death rate in the United States in 1912 was 13.9 and in 1915 it was 13.5, showing that the death rate has increased under compulsory insurance, and that the number of days of sickness has also increased.

A special commission appointed by the governor of Massachusetts to investigate health insurance reported to the legislature as not being in favor of it. The commission stated they found that the actual number of persons believing in and desiring the proposed insurance was surprisingly small, and there appeared to be two serious obstacles to the enactment of such a law; namely, the united opposition of the employer and employee to the plan, and the difficulties presented by the constitutional aspects to the questions. They also said they did not believe that health insurance would in any degree lessen poverty or so much of it as is due to sickness; that the true causes of poverty lie elsewhere, and it is no valid argument for an introduction of an otherwise objectionable system.

A commission was also appointed in California, and thus far, it has not favored such a law. There has been a great deal of agitation in California, where the society and its followers are making a desperate effort to put the scheme in operation. In a recent address a graduate of a German university likened the California workman to a chicken, saying that when a chicken-raiser found a sick chicken in the pens he didn't ask the chicken whether it wanted to be treated, but gave it the treatment he thought it should have, and he said a sick workman should be treated in the same way by the state. This is an example of German "Kultur," and as most of the countries of the earth are now fighting for democracy, it seems strange that health insurance should have gone as far as it has.

Organized labor is against the compulsory insurance scheme, also the great rank and file of the physicians of the United States. It is important that the medical profession of America organize to fight this German-made plan, as it is a scheme that has never been introduced in a republic. It was devised in Germany to meet the discontent of

the people, and to give their Prussian masters better control over them.

The law does not provide for treatment of chronic ailments, does not remedy the poor sanitary conditions under which people live and does not provide for the class of people who really need help; namely, those who have no regular occupation and make so little that they could not contribute, and therefore could not be insured. The profession would be expected to treat these people for little or nothing, as they do at present, the estimated cost would be very great in any state, and would enable grafters and politicians to add very largely to their incomes.

In a recent article the medical profession of England is represented as being very much pleased with the health insurance law, stating that the act is regarded as a distinct gain to the profession. This sweeping statement may well be questioned. The profession in England has always been progressive and we cannot be made to believe that it has been benefited under the insurance act. If their incomes have been increased under the act, then their previous incomes must have been insignificant so much so as to retard the profession and discourage the study of medicine.

The situation in Maine is somewhat different than in many other states. There are no large cities. The large cities are where we find the greater number of the poorer people and the dispensary class of patients. The population of the state is largely distributed through rural communities. Most of the towns are well supplied with doctors, and we have a goodly number of nurses, though many of the smaller towns are lacking in trained nurses, and this is common to all the New England states. Most of the larger towns in the state have one or more hospitals, but there does seem to be a scarcity of hospitals in some large counties, their being only one hospital in Washington county.

Owing to the long distance from hospitals many patients cannot avail themselves of hospital treatment. It would seem that there ought to be better hospital facilities in some of these isolated sections, even if the state had to step in and pay a good portion of the cost of maintenance.

Unemployment is a greater problem in the United States than it is abroad. In ordinary times the general statistics of unemployment have been from 20 to 30 per cent., but state officials inform me that the number of unemployed in Maine during ordinary times is very small.

The health insurance problem would also be different in this state

on account of rural conditions. The expense to the state would be enormous, and conditions instead of being better would be much worse, and a panel doctor located in an isolated town would have a definite number of patients on his list, and owing to the distance which he would have to go, he would have a very hard life, indeed.

The Commissioner of Labor states that 250,000 people are working for wages in Maine; that 150,000 are earning \$100 or less a month, at a conservative estimate. Elsewhere it has been suggested that a bill be drawn up which would also include people in business for themselves, property owners, etc., whose income is \$100 or less a month. If these people were included it would add many thousands of beneficiaries.

There is no need of any change in our present system of treating the sick. People are not being neglected, and the professional fees charged in Maine are not large. The workmen's compensation law has not been fully worked out in this or any other state, and there is considerable dissatisfaction, and attempts are made to curtail the doctors' fees.

What we do need in this state is compulsory school physicians, and this matter has been taken up in other states and considerable progress has been made. By conserving the children's health, the people can do much towards the elimination of diseases which cause much ill-health and loss of time in the future.

If more hospitals are needed in certain sections, it would seem that the profession should use their influence in having them established, as it is certainly a great handicap to be unable to give patients hospital treatment when they require it. We have a dispensary here in Portland, and if it is found that a considerable number of the poor in our other cities do not avail themselves of medical treatment, I think we should find a way of providing treatment for them.

CHAIRMAN COOMBS: Dr. Hart of Camden is requested to open the discussion of this paper:

DR. HART: *Mr. President, Gentlemen of the Association, and Visitors:* Events of the past three years have demonstrated plainly that not alone by shot and shell may Democracy be assailed; and so we may find that in compulsory health insurance it has a deadly foe. If memory serves me correctly, health insurance had its conception and birth in Russia, was nourished and developed in Germany, adopted with questional favor into France and England, and about five years ago a propaganda for its introduction into the United States was commenced. The American Association for Labor Legislation fathered it, and through this society's efforts bills for its introduction have been introduced into several states, but as yet with limited success. When we find in the list of officers and patrons of this society many names having their origin in Middle

Europe, it should set us to thinking. To be sure, many eminent men have favored this bill, President Wilson being among the number; yet even President Wilson makes mistakes. He said this nation was too proud to fight; nevertheless, he has seen it throw its pride under foot and prepare to fight to its limit. Dr. Alexander Lambert of New York, who at one time favored the bill, now repudiates it. Whatever comes to us labeled "Approved by Germany," should be carefully examined beneath its wrappings to see if there be not concealed a Prussian.

We take no exceptions to the statements made in the paper just read, and in the expression of our hearty approval, wish to emphasize four reasons why this bill should not be favorably received

First: It fails to attain its object. Having in mind the object to relieve distress and destitution occasioned by poverty and sickness, it does not reach the incompetent, the shiftless, the drunkard, and all others of that class who, for whatever reason, are unemployed, a class where poverty in its most marked type is found. The original bill also does not include the jobber and self-employed.

Second: It is unnecessary. The employer has learned that to keep workmen continuously employed is more economical than to change hands frequently. The law of industrial hygiene is being developed and no one will scarcely question but that in time the work already commenced in large manufacturing centers to thus conserve the laborers' health will become in this country universal. Under this plan all the benefits claimed through the wording of this proposed bill will be obtained; and, what is of greater importance, the dignity of true manhood will be developed rather than lessened.

Third: Its injurious effect upon medical science. Upon good authority it is claimed that under its influence the medical profession in Germany has deteriorated; that during the past twenty years out of Germany there has come but one therapeutic discovery of the first magnitude, and that is the product of a chemist.

Fourth: Its destructive influence upon the principles of genuine manhood, and therefore a menace to democracy. Had we time, we would like to elaborate this side of the question, for of the reasons given we consider this the most important. It is not a question of making money, but one of development of manhood and growth of democracy.

These four reasons given, backed up by sufficient data to prove their truthfulness, should be sufficient reason to consign this and all similar bills to oblivion. (Applause.)

CHAIRMAN COOMBS: Dr. Spalding will discuss the paper.

PRESIDENT SPALDING: If nobody else wishes to say anything in regard to health insurance, I would be glad to add the following remarks to the interesting discussion that has already followed the reading of Dr. Rowe's excellent paper.

In regard to Health Insurance, I am of the opinion that we should oppose it in every possible manner until it has been threshed out and some working plan discovered. I fear that, like all legislation in democracies, it will surely come, because every State copies the bad legislation of other States without studying results or comparing density of population and other items. What works well in a city may be hopeless for the country.

Do Maine employees suffer from lack of proper medical care at this time? Is it true, as some tell us, that in places where a workman's pay poorly supports a large family, physicians will not take the trouble to attend calls for sickness

because they get no pay? This has been said of Maine, and I ask if it is true. For we must answer such questions if put to us at a legislative hearing.

I cannot see why one set of people should be insured for health, whilst others just and deserving are not. People working on their own footing, teachers, small shop keepers and so on, making less income than many employees, deserve Health Insurance just as much as the better paid employees; but they are not looked at under laws so far proposed.

Prevention should be tried. School physicians would discover many diseases in children, and in time, would do largely away with all need for Health Insurance.

If Health Insurance is a good idea, it ought not to be used for unhealthy employees at the expense of the healthy, nor for the old at the expense of the young.

The population of Maine is scattered, and no fair scheme has been proposed to pay the country practitioner for his labor, his dangers of travel, and the long time demanded in getting to insured patients over bad roads during six months of the year. The English rural practitioner is treated most unjustly by the dead hand of the State, as the expression goes, paying for the cost of running a motor car 25 cents a mile, and getting paid 28 cents each visit. This wrong we must prevent when the time comes for such a law to be passed.

Treatment without choice of physicians is hopeless. Cheering words and encouragement from your own doctor shorten many an illness and get the man the sooner to working again.

Treatment by compulsion never succeeds. When the law compels you to go, and compels you to give drugs, and compels you to obey the orders of a politician, you cannot treat patients with any satisfaction. If you rebel, alone, you lose your panel, and your pay, and your private practice meanwhile has disappeared.

This business is a political scheme largely, to get an office to hold on to it, to boss somebody else, when prevention by physicians would be better for all. Let the people be taught to get out of draughts, to get better light, and to prevent dust getting into the lungs. Pass your hand of a morning in a smoke-infested city along the window-sill, where the window has been open all night, and see on your hand the vile smut which has sifted in during the night, and fancy if this fresh air in your sleeping rooms is really something good.

See what our first aid nurses in factories are doing to care for employees at work, and for their families at home; yet all this good work ceases with Health Insurance. "We have no need for you to help us, for if we get sick it costs us nothing to get cured. Send for the doctor; it costs nothing. He has to come when you send for him." Yes, indeed, and he gives of himself just as little as he can, just as little as human nature will let him give.

All this has been said before, I suppose, but it may strike you now as shining in a different light from that in which you are used to looking at Health Insurance.

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*Editorial Comment.***RESPONSIBILITIES OF STATE EXAMINING BOARDS
IN WAR.**

Dr. Sawyer, of Marion, Ohio, has sent to the JOURNAL a pamphlet on this important topic, and as it asks for some notice this much shall be said in brief. The responsibility of these boards hinges on the idea that they have a duty to perform in providing physicians for military and civil practice now and after the war. They originated in the idea of protecting the people from the unscrupulous. Underlying this, however, was better care of the people by better physicians. In other words, medical boards are to help humanity rather than physicians alone.

High standards are desirable in medicine, but we ought not to overdo it. What we need is a standard of service and not of theories. Many communities are suffering from lack of proper medical service. The idea now follows that standards for requirements should be minimized so that by demanding a lower standard we can fill the gaps caused by war calls on the practitioners of to-day. The present requirements from students of medicine are so exacting that a large number of capable men are turned down by the boards. To begin with, three years of education might be lopped off, two in the high schools and one in the literary college, so that men would be younger in beginning practice. So, too, they would thus save a large amount of money spent in educating them until they could become self-supporting.

The present idea of each State fixing its own standards is absurd. Let them get together and have one standard, so that now we can fill up the gaps and after the war supply the people. A federation of boards could throw out many requirements now insisted upon, geometry, percentage, arithmetical problems, dates in history, technicalities in physiology, grammar and so on. Medicine of the future should find the causes of disease, and treat them, rather than waste time in classifying them pathologically. Care, prevention and cure are bigger items than pathological findings. Theory is nothing alongside of what you can do in medicine. Conserve the time of students, get rid of the impracticables.

All these thoughts and suggestions bring up the still unanswered question of actual genuine RECIPROCITY, under which it takes some men years to get admitted to practice in one State after leaving another in which they have practiced successfully, brilliantly and satisfactorily to the community for years. This is a cruel wrong to physicians buying out the practice of other physicians or removing for family or other reasons from the former places of their successful career. Will this injustice, this crying wrong, ever be settled fairly to all concerned, not merely to the cultivated and skilled physician but to the community deprived of the opportunity of obtaining in his new place of residence and practice the same good service which that physician accomplished in his original State of registration.

J. A. S.

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Staten Island in ten hours and thirty-eight minutes. The hospital is a one-storied frame structure with convalescing porch, and has, in addition to the main ward, a diet kitchen, surgical dressing room, linen room, bath, and ward and officers' toilets. It is 150 feet long and 24 feet wide over all. Work was begun by digging the post holes at 7.00 A. M.; they were finished in eight minutes by 130 laborers. During the next hour 434 men, plumbers, carpenters and electricians, kept the work going ahead. As fast as the carpenters set the boards the plumbers followed with pipes and the electricians with their wires. Between 11.00 and 12.00, 566 men were steadily at work. At 5.38 the last nail was driven, the finished building was wired, lights ready to be switched on, and running water in the pipes.

Similar hospitals can be put up at any station when needed.

J. A. S.

A WORD ABOUT OUR NEW PRESIDENT.

A recent interview with our President, Dr. Coombs, gives one some idea of his activities in his effort to strengthen our organization and aid the government in carrying out its war program. The following is his program to date:

- June 18. Aroostook County Medical Society, Houlton.
Subject, "Medical Reserve Corps."
- June 26. York County Medical Society, Kennebunkport.
Subject, "Medical Reserve Corps."
- Aug. 1. Joint meeting of Kennebec, Franklin and Somerset
Medical Societies, Fairfield Sanatorium, Fairfield.
Subject, "Health Centers" and "Medical Reserve
Corps."
Meeting also addressed by Dr. Day, of Boston.
Subject, "Achromial Bursities."
- Aug. 13. Knox County Medical Society, Rockland.
Subject, "Health Centers" and "Medical Reserve
Corps."
- Aug. 15. Washington County Medical Society, Calais.
Subject, "Health Centers" and "Medical Reserve
Corps."
- Aug. 16. Hancock County Medical Society, Bath.
Subject, "Health Centers" and "Medical Reserve
Corps."
- Aug. 20. Piscataquis County Medical Society, Dover.
Subject, "Health Centers" and "Medical Reserve
Corps."

August 1st he attended a meeting at Augusta, representing the Medical Association, in the interest of establishing health centers for the control of infectious diseases.

Our President has set us all a good example, and if each member of the Maine Medical Association would ask himself just how he might help his country in this time of stress, the answer would be simple. First, if you are capable of service apply for a commission, and if refused turn to other avenues of service for the benefit of the government and the people.

Used In All Tests

THE report from the Laboratory of Physiological Chemistry of Jefferson Medical College, the Philadelphia General Hospital, and the Roosevelt Hospital, New York, of an investigation by Philip B. Hawk, Ph. D., and associated physicians, of the uses of yeast in diseases of the skin and of the gastro-intestinal tract, states:—

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PREVENTION OF MENINGITIS, DIPHTHERIA AND OTHER INFECTIOUS DISEASES IN THE ARMY CANTONMENTS.

Some exceedingly interesting work on the prevention of the infectious diseases originating in the nasopharyngeal tract is being done by army surgeons at various cantonments.

For instance, in an article on "Meningitis at Camp Greene," contributed by Capt. Paul G. Woolley to the *Journal of Laboratory and Clinical Medicine* for April, the statement is made that "In the only organization which made use of systematic nasal sprays since the first of the year, not a single case [of meningitis] developed, and also that in those organizations in which sprays were resorted to after the appearance of the disease no other cases appeared." The spray used at this camp was Dichloramine-T. Captain Woolley says that after this experience "one comes to have a very healthy respect for Dichloramine-T as an agent for the prevention of diseases of upper respiratory tract origin." He adds: "The organization numbered 7 in the chart has had the lowest measles and pneumonia rate in Camp Greene and is the only one which has systematically used the nasal spray. Its record is striking, and forms a reasonable basis upon which to recommend that the routine use of nasal spraying with Dichloramine-T be introduced into the camps for the prophylaxis of respiratory diseases."

Virtually, the same method of treatment was employed by Major Carey P. McCord, Major Alfred Friedlander and Capt. Robert C. Walker, at Camp Sherman, in the treatment of diphtheria, in an article published in the July 27th issue of the *Journal of the American Medical Association*, in which they state that in the treatment of these carriers they inaugurated the use of Chlorazene. They employed "an aqueous solution of 0.25 per cent. strength, administered as a gargle three or four times daily. In certain cases the application was made by throat specialists to insure the reaching of remote points in the nasopharynx. The gargling was followed with an oily spray of Dichloramine-T of 2 per cent. strength. It may not be maintained that the Chloramin action is exclusively responsible for the appreciable reduction of days in hospital of carriers. This is in part due to the Chlorazene-Dichloramine-T treatment and in part to the general painstaking systematizing of the entire care of such patients. Through the use of these several described procedures, it has been possible to return the carriers to duty after an average of twenty-three days in hospital. During the month of May our systematizing of treatment made it possible to discharge all diphtheria patients (sixteen in number) after fifteen days in hospital, and all carriers (twenty-nine in number) after sixteen days in hospital."

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Personal News and Notes.

Lieut. C. B. Sylvester, M. R. C., President of the Cumberland County Medical Society, now in the service, has written us a delightful letter, one item concerning the lamented death of our comrade, Lieut. Coombs, of Westbrook, and another enthusiastic paragraph on tuberculosis reconstruction, in which he is at present deeply interested and engaged. The JOURNAL is always glad indeed to hear from Maine physicians in the Medical Reserve Corps, praises the example which they have set for us all, and encourages them when opportunity serves to keep in communication with all here at home. Although we watch the course of affairs abroad with keener interest, perhaps, it is equally true that we keep an eye on the medical improvements which our men in the base hospitals throughout the country are daily doing for the good cause.

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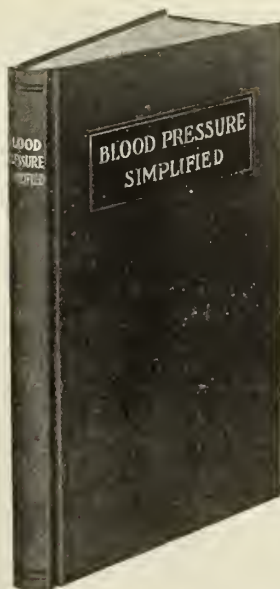
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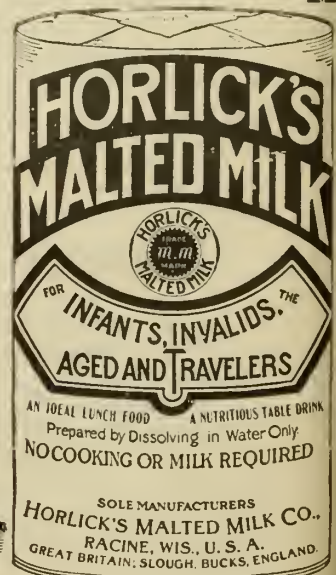
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The Journal assumes no responsibility for opinions expressed by the authors.

VOL. IX.

OCTOBER, 1918.

No. 3

*THE CANCER PROBLEM.

By LEVERETT D. BRISTOL, M. D.,

State Commissioner of Health, Augusta, Maine.

INTRODUCTION.

I have four reasons for having chosen the subject of cancer for discussion at this time. First, because practitioners usually desire something which has a distinct clinical bearing; secondly, because all medical men, no matter what their specialty may be, are interested in malignancy; thirdly, because it is one of the subjects which I have studied the most from laboratory and experimental standpoints, and have formulated my own hypothesis as to its cause; and lastly, because the American Society for the Control of Cancer has asked me to act as chairman of its State Committee for Maine, with the request that I choose the other members of such a committee.

The present paper is somewhat in the nature of a summary of my previous publications on this subject, including even definite quotations from such papers.

HISTORICAL NOTE.

The first knowledge of cancer dates back to the beginnings of medicine itself, and is one of the most ancient of diseases. According to history, it was known to the peoples of early Egypt, India and Greece. Such men as Hippocrates, Galen, Celsus and Leonidis were familiar with it, and records of operations for cancer date back at least to 180 B. C.

(* Abstract of a paper read at a meeting of the Waterville Clinical Society).

STATISTICAL DATA.

At the present time the mortality from cancer throughout the world is over 500,000 a year, while in the United States it is about 80,000. It seems to be increasing at an approximate rate of 2.5% per annum in contrast to the gradual decline in the general death rate.

For those over 40 years of age cancer is a greater menace than pneumonia or tuberculosis. It causes one death in every eight women and one death in every fourteen men.

During the year 1916 there were 844 deaths from cancer in the State of Maine; 308 were males and 529 females. This is the highest cancer mortality in the history of the State. In 1892 (the first year of our statistical records) there were 404 deaths.

CLINICAL ASPECTS.

It is unnecessary for me to dwell at any length on the symptoms and signs of cancer. The symptoms-complex of the advanced cases are all too well known to us, although there is no definite pathognomonic sign. What I desire to specially emphasize is that in its earliest and curable stage cancer may cause no pain or symptom of ill health. The following instructions to the laity as to the early signs of cancer are worthy of emphasis:—

“In case of any swelling occurring in the breast of a woman after forty years of age, a medical man should at once be consulted. A large proportion of such swellings are cancer.

“Any bleeding, however trivial, occurring after the change of life means almost invariably cancer, and cancer which is then curable. If neglected till pain occurs, it means cancer which is almost always incurable.

“Any irregular bleeding occurring at the change of life should invariably be submitted to a doctor's investigation. It is not the natural method of the onset of the change of life, and in a large number of cases means commencing cancer.

“Any wart or sore occurring spontaneously on the lower lip in a man over forty-five years of age is almost certainly cancer. If removed at once the cure is certain, if neglected the result is inevitably fatal.

“Any sore or swelling occurring on the tongue or inside of the mouth in a man after forty-five years of age should be submitted to investigation without a moment's delay, and the decision at once arrived at by an expert microscopical examination whether it is cancer or not. A very large proportion of such sores or swellings occurring at this time of life are cancer, and if neglected for only a few weeks the result

is almost inevitably fatal. If removed at once the prospect of cure is good.

"Any bleeding occurring from the bowel after forty-five years of age, commonly supposed by the public to be 'piles', should be submitted to investigation at once. A large proportion of such cases are cancer, which at this stage are perfectly curable.

"When warts, moles, or other growths on the skin are exposed to constant irritation, they should be immediately removed. A large number of them, if neglected, terminate in cancer.

"Avoid irritation of the tongue and cheeks by broken, jagged teeth, and of the lower lip by clay pipes. Many of these irritations, if neglected, terminate in cancer."

DIAGNOSIS.

A correct diagnosis is often possible based on the clinical history of a case, but in the earliest stage of the disease a microscopic examination is usually necessary. Let me also emphasize that there are certain tumors which are often difficult for even a skillful pathologist to diagnose, and it is just as necessary for the pathologist to have a detailed history of the case as it is for the surgeon.

A year or so ago the writer served as the chairman of a special committee appointed by the American Society for the Control of Cancer to make a survey and report in regard to the existing facilities in Public Laboratories of the various States of the country for examination of specimens of suspected cancerous tissue. The following recommendations were submitted as worthy of consideration in the campaign against cancer:

1. So far as consistent with local conditions, facilities should be offered under public auspices in each State for the diagnosis of tissue suspected of being cancerous. Preferably, these should be made free of charge.

2. The logical place for the doing of such work is the laboratory of the State Health Department. It is not to be supposed that such work will be given the preference over other work now being done by these laboratories.

3. To cover this work, in those States which have no such facilities, additional money should be appropriated.

4. Judgment must always be used by surgeons in the removal of suspected cancerous tissue for diagnosis, and the value of a microscopic diagnosis should appear to outweigh the risk involved before such a procedure is adopted.

Such facilities were offered for the first time in Maine under the auspices of the State Department of Health on January 1, 1918.

CLASSIFICATION.

Tumor classifications are numerous and in most instances unsatisfactory. Probably the best classification which has been attempted in recent years is that of White, which is as follows:

CLASSIFICATION OF TUMORS.

A. Organomata, or Organ Tumors.

1. Teratoma.

B. Histiomata, or Tissue Tumors.

(a) Desmomata, or Supporting Tissue Tumors.

- | | |
|---------------|---------------------|
| 1. Myxoma, | Mucous tissue. |
| 2. Fibroma, | Fibrous tissue. |
| 3. Lipoma, | Fat. |
| 4. Chondroma, | Cartilage. |
| 5. Chordoma, | Notochordal tissue. |
| 6. Osteoma, | Bone. |
| 7. Odontoma, | Dentine. |
| 8. Glioma, | Neuroglia. |

(b) Neuromata, or Nerve Tumors.

- | | |
|-------------|-----------------|
| 1. Neuroma, | Nervous tissue. |
|-------------|-----------------|

(c) Myomata, or Muscle Tumors.

- | | |
|-----------------|------------------|
| 1. Rhabdomyoma, | Striated muscle. |
| 2. Leiomyoma, | Smooth muscle. |

(d) Lymphomata, or Lymphoid Tissue Tumors.

- | | |
|--------------|------------------|
| 1. Lymphoma, | Lymphoid tissue. |
| 2. Myeloma, | Bone marrow. |

(e) Epithelial and Endothelial Histiomata.

Papilloma.
Adenoma.
Angelioma.

C. Cytomata, or Cell Tumors.

(a) Blastocytomata, indifferent cells (mixed).

(b) Sarcomata (Desmocytomata), supporting tissue cells.

- | | |
|----------|-----------------|
| 1. Pure. | Round celled. |
| | Spindle celled. |
| | Melanotic. |
| | Giant celled. |

2. Compound.

Myxo sarcoma.

Fibrosarcoma, etc.

- (c) Neurocytomata, nerve cells.
- (d) Myocytomata, muscle cells.
- (e) Lymphocytomata, lymphoid cells.
- (f) Carcinomata, epithelial and endothelial cells.
 - 1. Squamous—celled (epithelioma).
 - 2. Columnar—celled.
 - 3. Spheroidal—celled (Scirrhus).
 - 4. Syncytial—celled (Synctioma) (Chorionepithelioma).
 - 5. Endothelial—celled (Endothelioma).

ETIOLOGY.

In a consideration of the etiology of cancer I propose first very briefly to review and criticise the older theories of neoplasia, and will then call your attention to some original ideas on the subject.

Let us briefly consider the older theories of Cohnheim, Ribbert, von Hanseemann, Adami, Hauser, Oertel and Marchand, and the so-called "parasitic theories."

According to Cohnheim's theory (one of the most popular) a neoplasm originates in displaced embryonic cells or "rests." While this may be true in some cases, it cannot explain the origin of all kinds of tumors. Furthermore, this theory does not explain the reason for, nor the stimulus to, a sudden division of the supposed cell "rests."

Ribbert believed that a cell displacement is necessary, but that a tumor results because of a decrease in the external resistance and forces which oppose the growth of cells. This theory does not reveal the cause for the sudden change from the normal to the abnormal.

Von Hanseemann's theory of anaplasia suggests that certain abnormal cells exist which have an increased vegetative activity, but are unable to attain normal structure and functions. This he believes is due to an abnormal distribution of nuclear material in the cells. Again this theory is applicable only to malignant tumors, and suggests no stimulus.

Adami tells us that cancer may be due to cells losing their habit of function and acquiring the habit of growth, at which point the neoplasm starts. This gives us no idea of what the force might be that could cause such a changed condition.

Hauser's theory would lead us to believe that certain cells—descendants of the ovum—may show a variation from the normal in a very much more active vegetation than their related cells, just as there

may be marked variation in one species of animals, plants, bacteria, etc. The descendants of such cell variables would form a neoplasm. This is too much a question of heredity and predestination and does not explain those tumors which follow in close association, injuries and irritations.

Oertel states it as his belief that two orders of chromatin exist in the single nucleus, one governing function, the other influencing growth. A cancer cell, he believes, is one which has lost the chromatin governing function and its descendants have only the power of proliferation. This does not explain why certain cells should proliferate in a malignant manner, neither has it ever been proven that two such orders of chromatin are present in a cell nucleus.

Marchand holds that for a malignant tumor to develop there must first be a local cell degeneration, and that in some way this abnormal cell has an action on the other cells in the neighborhood, causing them to take on a malignant proliferation, although he describes no detailed forces which might be concerned in such an action.

That cancer is caused by a micro-organism or parasite is a view that has had many ardent supporters. Practically every form of micro-organism, including bacteria, protozoa, and animal and vegetable parasites, has at one time or another been accused of being the cause of cancer. To me the very multiplicity of parasites supposedly "demonstrated" to be the specific cause of cancer is the greatest argument against the theory. On the other hand, we may include any or all of these micro-organisms as predisposing causes leading to the precancerous stages of cell degeneration or disordered metabolism, admitting at the same time that many entirely different forces may lead to the same cell derangement.

The writer has endeavored to formulate a new working hypothesis concerning the cause of tumors in general and of cancer in particular; this I have designated as an Enzyme Theory of Cancer Etiology.

As a primary cause of cancer it would seem that some form of cell or tissue degeneration is necessary. Also it appears that this degeneration may be due to one or more causative factors, which can be divided into two groups: 1. The interference with the nutrition, or blood supply to a part. 2. Cell or tissue injury, due to the following means: (a) Mechanical (wounds, etc.); (b) chemical (poisons, etc.); (c) physical (heat, light, etc.); (d) parasitical; (e) functional (over-activity, disuse).

Everyone is familiar with the close association between cancer and a history of a previous injury, chronic irritation or chronic inflammation. Because we can obtain no history of previous injury, chronic

inflammation, or irritation in a case of cancer may we justly say that none of the above factors, some of which may be unfelt and unseen, has been the cause of a primary cell or tissue degeneration? May not certain things affecting the blood supply, certain protoplasmic poisons, heat or light rays, or bacteria have been at work in the past to cause cell degeneration absolutely unrecognized by the diseased person or his physician? The importance of "precancerous" lesions cannot be overestimated.

As a secondary step in the chain of events leading to a malignant proliferation of cells, we would mention the normal inflammatory reaction resulting from the above mentioned injuries, and the affinity of these primary "precancerous" areas for certain inorganic salts of the blood, as well as a marked change in their chemical structure and metabolic activities, resulting in the concentration and acceleration of normal intracellular oxidizing enzymes and co-enzymes in these areas of injury and inflammation. The catalytic effect of these enzymes causes a "speeding up" of local cell oxidations and leads to a marked increase in growth rate and of division rate upon which the other characteristics of cancer depend. These new enzyme amounts and powers may be transmitted naturally to the offspring of the cell or cells in which the change was initiated, and, as a consequence, these newly acquired rates of oxidation, growth, and division become permanent, if not checked by the enzymes and anti-enzymes which protect the body against such injurious cell oxidations.

For lack of space a detailed description of enzymes and their action, and their relation to cell growth and division, is not possible here. For such details the reader is referred to the writer's previous papers on the subject.

Cell proliferation in tumors is different from cell proliferation under normal conditions primarily in degree or speed. In tumors, local cell reactions have been greatly accelerated and the growth rate is much faster than in normal cells, and is possibly dependent upon increased concentration and activity of oxidizing enzymes or catalyzers, with a lack of their proper inhibition. Howard and Schultz have shown that the other characteristics of a tumor cell, such as increased division rate, lack of differentiation, etc., are dependent upon increased growth rate. The important thing to explain, then, is the agent or force which initiates the change from normal cell growth rate to tumor cell growth rate, and which results in a permanent acceleration of energy in a local cell or mass of cells.

Howard and Schultz believe that "Dynamic energy, produced by cellular metabolism, manifests itself in cellular growth and function.

. . . In the malignant tumor cell the maximum limit of energy production for the normal cell is overstepped and the energy produced is abnormally distributed to the advantage of growth, rather than of function." Carrel says: "The dynamic condition of a tissue is manifested by the rate of its growth." From this, may we not conclude that the excessive growth rate of tumors is a manifestation of increased dynamic force and energy in the individual cells involved? If so, does not the cancer problem resolve itself into a question of increased dynamic energy of local cells, and an upset in cell oxidation equilibrium? Is it not proper to first consider how the normal sources of cell energy might be associated with this change, instead of looking for some extrinsic agent such as a parasite? "It must be remembered that in cancer we have cell proliferation going on at a rate which is unknown in any other condition in grown-up animals, and many of the appearances, both as regards the irregularity of mitosis and as regards cell inclusions, may be the result of this great rapidity of proliferation," says White.

What is the cause of this "overstepping" of normal cell energy, or of this acceleration in localized biochemical activities leading to accelerated energy production and growth? In the answer to this question, we believe, may be found the explanation of the "formative stimulus" of tumors.

The writer believes that the cause of this local acceleration is the catalytic action of local, concentrated oxidizing enzymes, or an increase in their co-enzymes (accelerators), in one or more previously normal cells; these cells may take on a new independent energy production and growth rate as a result. The transmission of this newly acquired concentration, or accelerated action, of endoenzymes from parent cell to daughter cells assures the progeny a permanent and independent increase in oxidations, energy production, growth rate, and division rate, in a localized area. This concentration may be brought about through the process of injury and inflammation (especially chronic) as outlined above, in which the leucocytes are attracted to a local area where their enzymes are liberated in an abnormal amount, over an extended period of time. Injury (mechanical, chemical or parasitic) may also be of importance in first causing a cytolysis of the lipoids of the normal, but potential cancer cell (as has been shown by J. Loeb to be the case in the natural fertilization of the egg, or in so-called "artificial parthenogenesis"). We must admit, also, that there are other forces, such as light and heat rays, which may directly stimulate local enzyme activity, or which may attract and cause the localization and concentration of enzymes themselves. In fact, the writer

believes that cancer of the lip in clay pipe smokers, cancer of the scrotum in chimney-sweeps, and cancer of the skin in wearers of the hot charcoal kangri basket, are due in large part to the attraction, concentration, and acceleration of enzymes by the localized absorbing clay or carbon, in addition to a rise in temperature, followed by increased oxidations permanently established in such local areas.

Buyo cheek cancer, prevalent in the Philippine Islands, seems to be caused in a very definite manner by the irritation of the buyo which is chewed by male and female natives. Buyo consists of a mixture of buyo leaves, betel-nut, slaked lime and tobacco. Davis believes that the active agent in the causation of the buyo cheek cancer is the lime. From a study of enzymes it is found that lime may act as an absorbent and concentrator of enzymes, while it is also learned that calcium is an important activator of enzyme action (a co-enzyme). In connection with cheek cancer it may act by catalytically "speeding up" the enzyme action and oxidations of local epithelial cells.

Richards says: "The speed of the chemical changes in the human body is a matter of capital importance to man. Indeed, it may be said that the difference between health and disease, between life and death, is primarily a question of the relative speeds of the various reactions concerned in the act of living. There is, fortunately, a wide margin of safety, but nevertheless, if anyone of the more essential chemical changes takes place too fast or too slowly, illness is certain consequence. All chemical reactions are dependent for their speed upon a few very definite circumstances, to wit: the special affinities of the substances concerned, the concentration of the reaction substances, the temperature of the mixtures, and the presence or absence of certain other substances (called catalyzers or catalysts) which do not themselves take part, but which stimulate the reacting substances to enter into combination. Each of these factors in the result is of great importance to the biologist. The effect of concentration is especially interesting."

The above statements would seem to apply to individual cells, as much as to tissue, organs or the body in general. According to our enzyme theory, the difference between a normal cell and a cancer cell is essentially a difference in the speeds of their biochemical reactions, depending upon a difference in their intracellular enzyme and co-enzyme concentration and activity, more especially of their oxidizing enzymes.

According to our theory, therefore, cancer is the result of an abnormality in local cell energy due to a combination of a local "formative stimulus," in the nature of concentrated oxidizing enzymes or accelerating co-enzymes, in one or more previously normal epithelial

cells, with a general or local decrease (either hereditary or acquired) of the enzymes and anti-enzymes which control cell oxidation and proliferation.

TREATMENT.

Granting at the present time that early surgical removal is the most satisfactory method of curing cancer, there still remains the hope that a day will come when a successful non-surgical treatment of cancer may be realized. For centuries, competent investigators have been seeking this goal, but without success. With the exception of toxic gases, practically all of the possible chemical, physical and biological agents have been tried, including cell poisons, caustics, electricity, heat, light (visible and invisible rays), "vaccines," sera, and cell or organ extracts. The chief difficulty has been the finding of an agent which has a specific destructive effect on the cancer cell without an injurious effect upon the surrounding healthy tissues. It must be admitted that a rational non-surgical treatment awaits the demonstration of a specific causal agent, or of a logical explanation of such an abnormality based on a thorough study of the chemistry and physics of protoplasm in general, and of the living cell in particular.

Based upon my own hypothesis, that cancer is the result of localized, unchecked over-combustion, or hyperoxidation, in epithelial cells, a rational treatment of the disease might involve the inhibition of such "hyperoxidations," or the complete asphyxiation of the cancer cells. This possibly may be brought about directly by attacking the intracellular oxidizing enzymes (upon which cell oxidations, growth and multiplication so largely depend), or by renewing those enzymes in the body whose function it is to combat injurious cell oxidations. The asphyxiation of the cancer cell involves (1) the withholding of oxygen (so necessary for cell life), either by cutting off the blood supply or by absorbing the oxygen itself before it can be of service to the tumor cells; or (2) the introduction of sufficient carbon dioxid, or toxic gases, to cause the suppression of oxidations in the tumor cells. It is evident that even such a treatment must be confined to the cancer cells, for the general effect would be to kill all of the body cells. Herein lies the chief difficulty in its practical application.

PREVENTION AND CONTROL.

The prevention and control of cancer will depend largely on the education of the people regarding the early signs and curability of the disease and the importance of the so-called "precancerous" lesions. In addition to this, people must be taught the absolute necessity for

consulting a physician *immediately* when any suspicious lesion or sign shows itself. The periodic physical examination, even during apparently good health, will be the means of preventing cancer as well as many other diseases.

The American Society for the Control of Cancer, which is the chief educational agency interested in this disease, was formed in New York City on May 22, 1913, and numbers among its officers and directors some of the leading laymen and physicians of the United States. Its purpose is "to disseminate knowledge concerning the symptoms, diagnosis, treatment and prevention of cancer, to investigate the conditions under which cancer is found, and to compile statistics in regard thereto." It is the direct result of action taken by the American Gynecological Society upon recommendations submitted to that organization by Frederick L. Hoffman, of New York City, on May 7th, 1913. It has the official approval of all the leading national and state medical and surgical societies.

In closing, I desire to name the following physicians to serve with me on the Maine State Committee of the American Society for the Control of Cancer. There are no obligations involved other than a willingness to assist in a campaign of education in our State, regarding cancer and the means for its suppression.

COMMITTEE FOR MAINE.

Dr. D. C. Cragin, Waterville.
Dr. A. D. Sawyer, Fort Fairfield.
Dr. W. N. Miner, Calais.
Dr. E. B. Sanger, Bangor.
Dr. W. E. Webber, Lewiston.
Dr. G. H. Coombs, Waldoboro.
Dr. Walter E. Tobie, Portland.
Dr. L. D. Bristol, Chairman, Augusta.

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JOURNAL OF MAINE MEDICAL ASSOCIATION

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*Editorial Comment.***THE PORTLAND PSYCOPATHIC CLINIC.**

This important adjuvant to medical practice and efficiency in Maine is very quietly doing good work in its office in the basement of the City Building. At a recent call on the physician in charge, Dr. Carter, of the State Hospital at Augusta, in the absence of Dr. Tyson, superintendent of that hospital, we were much pleased to note the steady progress of examination of cases from week to week. In the three months during which the experiment has been tried for the first time in the history of the State, a considerable number of applicants have been received, questioned, accurately noted in proper Case Books, and put into a direction tending to improvement. It is not yet time for the JOURNAL to mention all of the cases examined, or to offer tables or statistics to show the great public need and benefit of this clinic, but at the end of at least six months from the date of its establishment we intend to offer further remarks concerning its value to the State and to the community, accompanied with suggestions for progress from the physicians in charge of the work.

For altogether too many years the study of the psychology of their patients has been neglected by the physicians of the State, and in putting before them in due season the results so far obtained by this clinic there can be no doubt that the patients of many practitioners of medicine will be advantaged and improved by contact with these experts in the study of psychology and mental or nervous aberrations from health. It is indeed as notorious as it is unfortunate

that a large number of patients who ultimately drift into the insane hospitals, here and elsewhere, might in point of fact have been kept on the right side of health and sanity for life by earlier study of the prodromes of this unfortunate mental disease which we call insanity for lack of a better word. All of these poor creatures are lost to the advance and improvement of the State by life-long imprisonment in hospitals, when a large proportion of them might have remained useful members of the community if taken in hand by their medical advisers earlier in life, and put into shape by consultations with experts as provided for at last by the State in the shape of these psychopathic clinics.

J. A. S.

MAINE VOLUNTEER MEDICAL CORPS.

The governing board of this corps has been chosen and stands now in this order: Dr. G. B. Swasey, of Portland, President; Dr. John T. Palmer, also of Portland, Secretary. The other members are Dr. J. D. Haley, of Saco; Dr. W. F. Hart, of Camden; Dr. R. H. Marsh, of Guilford, and Dr. W. H. Harris, of Augusta.

The County representatives are Dr. C. E. Williams, of Auburn, for Androscoggin; Dr. H. L. Putnam, of Houlton, for Aroostook; Dr. B. F. Dunn and Dr. H. F. Twitchell, for Cumberland; Dr. J. W. Nichols, of Farmington, for Franklin; Dr. Lewis Hodgkins, of Ellsworth, for Hancock; Dr. J. F. Hill, of Waterville, for Kennebec; Dr. F. B. Adams, of Rockland, for Knox; Dr. G. H. Coombs, of Waldoborough, for Lincoln; Dr. B. F. Bradbury, of Norway, for Oxford; Dr. D. A. Robinson, of Bangor, for Penobscot; Dr. Hiram Hunt, of Greenville, for Piscataquis; Dr. J. O. Lincoln, of Bath, for Sagadahoc; Dr. L. A. Dascomb, of Skowhegan, for Somerset; Dr. Adelbert Millett, of Belfast, for Waldo; Dr. H. B. Mason, of Calais, for Washington, and Dr. J. D. Cochrane, of Saco, for York.

With these able physicians the Volunteer Medical Corps will surely do excellent service for the civil population of Maine, denuded by war needs of its normal quantity and proportion of younger physicians, to say nothing of taking care of emergency cases in the various hospitals throughout the State.

AVIATION PHYSICIANS.

As we are sure that some of our members from the Maine Medical Association are eager still to volunteer against the Huns, it is proper that at this time we should emphasize a few points for examinations and practice in which our men should post themselves in

advance of asking for or obtaining a commission. Although it would seem at first glance that the only occasions for medical services to an aviator would consist in caring for injuries received from falling and being later dragged along by his machine, it is very plain from the delightful letter which we print elsewhere from an aviator, whom many of us know, that there are many other things and much other special knowledge needed for which the aviation physician and surgeon should be prepared.

Amongst these we call attention to an incident in the previous letter, in which a skilled aviator went all to pieces suddenly, damaged his own and other machines, and nevertheless in whose eyes or ears nothing wrong could be discovered. Such a lapse as this was undoubtedly due to total loss of consciousness, to insufficient oxygenation of the blood, to a state of dreaming, brought about by lack of contact with the earth on which the man had passed all of his former life, or to some unknown nervous cause produced by indigestion. It may have been due to lack of something tangible close at hand, or it arose from gazing hour after hour at mere banks of mist, which we call clouds, without any real solid objects to be seen to recall the mind to actual facts. In other words, the cause of such an accident—and they seem by no means uncommon with even skilled aviators—is guesswork so far, and here is a problem for the aviatory physician to solve for the saving of life and airplanes. Then, again, such physicians have to study the effects of food, its digestibility, the proper time of ingestion before aviating; and, in a word, here is a second topic for the expert to study and make plainer than is so far known to other observers of to-day.

Variations in blood pressure occur in most of our aviators, and the ability of each man's heart to withstand convincingly an increased blood pressure at varying heights will need investigation. The condition of the nasal mucosa as altered by oxygen inhalation and high altitudes, and the relation of its condition before and after oxygenation to the mucosa of the middle ear and the organ of hearing, need thinking over carefully.

Although the imbalance of the eye muscles and the static condition of the labyrinth are as a mere matter of routine gone over thoroughly before the aviator is accepted, yet there is much still to be learned considering these conditions immediately or at a few hours after alighting from the air. Nor should we forget the exceedingly important question of the condition of the nervous system, as influenced not only by the mere attainment of lofty altitudes, but we must consider the effect of loneliness, and of slight personal defense against flying enemies, and the wonderfully important question of so alight-

ing as not to fall on foreign or even neutral soil, and so becoming an actual or an involuntary prisoner for the rest of the war. In either event, such a fate is cruelly suggestive to the keen aviator and volunteer for freedom. Then, again, there is shell shock even in the air, for instances have been reported of very close contact with the air driven forward at great heights and with immense velocity and impetus from the great shells of to-day, and followed by an evident nausea, imbalance and dizziness long afterward. Finally may come the question of the nervous influence dependent on making a good homing amidst your own fellows of the army to which you belong.

As this suggestive note merely hints, there is much for the physician interested in aviating to study, and it is our hope that these hints will induce more medical men to volunteer from amongst our numbers and to fight for the freedom of the seas and the liberty of the world.

J. A. S.

NEW AND NON-OFFICIAL REMEDIES.

During September the following articles have been accepted by the Council on Pharmacy and Chemistry for inclusion with New and Non-official Remedies:

Non-proprietary articles:

Benzyl Alcohol.

Armour and Company:

Corpus Luteum Capsules, 2 grains.

Thromboplastin Solution—Armour.

Gilliland Laboratories:

Antipneumococcus Serum, Type I.

Hynson, Westcott and Dunning:

Phenmethylol—H., W. and D.

Phenmethylol Ampules, 1 per cent.—H., W. and D.

Phenmethylol Ampules, 2 per cent.—H., W. and D.

Phenmethylol Ampules, 4 per cent.—H., W. and D.

Riedel and Company:

Salipyrine Tablets, 7 1-2 grains.

E. R. Squibb and Sons:

Chlorcosane—Squibb.

Halazone—Squibb Tablets, 1-16 grain.

Solargentum—Squibb.

Correspondence.

UTILIZATION OF PLATINUM IN UNUSED INSTRUMENTS.

To the Doctors and Dentists of the Country:

1. In view of the limited supply of platinum in the country and of the urgent demand for war purposes, it is requested that every doctor and dentist in the country go carefully over his instruments and pick out EVERY SCRAP OF PLATINUM that is not absolutely essential to his work. These scraps, however small and in whatever condition, should reach governmental sources without delay, through one of two channels:

(a) They can be given to proper accredited representatives of the Red Cross, who will shortly make a canvass for that purpose.

(b) They may be sold to the government through any bank under the supervision of the Federal Reserve Board. Such banks will receive and pay current prices for platinum.

By giving this immediate attention you will definitely aid in the war program.

2. It is recognized that certain dental and surgical instruments requiring platinum are necessary, and from time to time platinum is released for that purpose. It is hoped, however, that every physician and every dentist will use substitutes for platinum for such purposes wherever possible.

3. YOU ARE WARNED against giving your scrap platinum to anyone who calls at your office without full assurance that that individual is authorized to represent the Red Cross in the matter.

LIEUT. COL. F. F. SIMPSON, M. C., N. A.,
Chief of Section of Medical Industry.

NOTES.

EYE PATIENTS AT HALIFAX IN 1917 CALAMITY.

We take a bit of space from other topics to make this printed statement, that the total number of eye patients discovered and treated in any way, shape or manner at Halifax was 760. Forty-four of these are reported as totally blind, nine died, more than a third of them are still under observation in regard to proper treatment by delayed operations or change of proper lenses.

PRURITUS ANI.

This disagreeable affection produced in many ways from many different causes is last of all referred to pyorrhœa alveolaris, and we are seriously told that cases of this disease can be and have been completely relieved by local treatment as applied to the disease of the teeth.

BIRTH CERTIFICATES.

During the past year much attention has been paid to reminding physicians of extreme care needed in registering birth and death certificates. A goodly number of physicians seem to consider the need as very problematical indeed. Careful study, however, of the number of visits and letters asking for information of this sort in New York City alone showed over 100,000 inquiries in the past year. Undoubtedly proportional numbers were asked in Maine, for school, mercantile inheritance and recruiting purposes.

THE X-RAYS IN DIAGNOSIS OF STOMACH DISEASES.

So many physicians and surgeons are so sure that all that is needed to make a positive diagnosis of stomach conditions is to be found in the use of the X-ray that it is worth noticing that Meyer, in the *Medical Record*, N. Y., May 18, emphasizes the undeniable fact that over and over again incorrect interpretations have occurred after such skiagrams. It is only in a minimum number of cases of stomach affections that the X-rays can be relied upon solely as a means of diagnosis. To combine this necessary step with all other means at your command is sound advice in affections of the stomach.

War Notes.

A LETTER FROM AN AVIATOR.

So much has been written, spoken and said concerning the symptoms exhibited by the eyes and ears of aviators, from notes made by medical men on the spot, that it occurred to me to ask an aviator over there to give me his own verbal expression of how his eyes and ears behaved during his flights. An answer, altogether too short, perhaps, for so important a topic, has at last reached me, and I give it over to the readers of the JOURNAL, as an agreeable and actual impression of how it seems to the aviator himself.

J. A. S.

September 24, 1918.

FROM OVER THERE, End of August, 1918.

Dear Dr. Spalding :

I was very glad indeed to receive your letter this very day and will gladly try to answer your questions at once, trusting at the same time that they will be of some little use and interest to you.

I have already done nearly fifty hours of aviation this month, at altitudes ranging from 12,000 to 20,000 feet, and as a result of that experience I have become more or less accustomed to the high altitudes, although their peculiar effects upon me have not changed much from what they were on my first fly to such a height. Most of the looking about in an airplane is over the sides, and no matter whether you look straight ahead, or down, or at various angles, there is no dizziness such as you may often have perceived on top of a high building. The glass bomb-sights are in the bottom of the plane, and if for any length of time you look down through them and see the ground moving along, you do get a slight bit of dizziness. But as these sights are never used more than a fraction of a minute in succession, the sensation amounts to nothing at all. When the atmosphere is rather misty the higher you go the better you see in the distance. As for recognizing objects from a great height, it is just a matter of becoming accustomed to continuous flying, and regardless of profile it is usually easy to make out different objects. An altimeter always gives you at a glance your correct height in the air, although up to 10,000 feet you soon become accustomed to judging your height by looking over the side. Goggles are always worn, and your helmet is so arranged that you can almost completely protect your face against frost bite. This precaution is, however, only

necessary around a height of 20,000 feet or more.

The moving below you of trains, engines, motor cars, motor trucks, and so on can only be made out exactly by taking for sights two points on the road beneath you; take the time of the trains, etc., hitting them, and so gather some idea of the speed, distance and direction. Of course with a railroad train you can almost always see enough smoke for a trail to guess by.

As to getting used to flying, it soon becomes the same thing as getting used to the sensation of a motor car, that is to say, the flying part does, but by no means the fighting part.

The eyes are rarely bothered by flying, but the ears, heart and lungs are all affected, and oftentimes considerably at high altitudes. To relieve the pressure on the heart we have our oxygen tanks, with a tube fitting into our helmets and mouth. Some men need oxygen anywhere over 12,000 feet, some not until at 20,000; some need take only several inhalations every ten minutes or so, and some need it all the time when high up to prevent fainting dead away and a sensation of sickness at the stomach.

You cannot hear better at high altitudes unless you continually clear your ears by either swallowing or holding your nostrils and blowing with your lips slightly closed. If you come down from high altitudes, say at a speed of about seventy-five miles an hour, which is customary, the pressure causes great pain in the eardrums unless you swallow continually. And always when you land it is very difficult to hear; you feel as if you were talking very loud to yourself,



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(2020)

and your ears sing and ring for three or four hours steadily afterward.

So far as concerns the importance to aviators between good eyes and good ears, there is no doubt that the eyes are by far the most important. Some doctors have urged that the ears affected your sense of balance at high altitudes, but I have never felt so myself, or ever heard of any instances. But the eyes appear the most difficult to judge about for aviators. There is a fellow whom I know who passed the medical examinations last year and has been perfectly all right ever since, yet only a few days ago he suddenly, as he expressed it, saw all ways at once, and very nearly crashed into two other air machines in our formation. He has stopped flying for the present, but nothing much can be found wrong with his eyes. For all that, one of them is a little bit weaker than the other.

The judging of distance in the air is our main difficulty, and it is just the same as at sea or over any wide expanse of level country without landmarks. It is very hard to tell the distance away of another machine coming directly toward you. I have had an observer, or as you might say a gunner, fire at a German machine when it was easily ten miles away. Of course, if a plane is coming at you at the rate of 100 miles an hour, and you are making the same speed toward it, it does not take long for you to get in range with each other, but firing under 500 yards is usually not much good.

I am afraid that my little information is not worth very much to you, yet I will end by saying that in flying speed makes no difference to the eyes, ears, or anything else; it is all altitude. At times, however, you find a man who cannot quickly judge distances near the ground or on landing, and crashes into machines, so that he feels put out, yet at over 500 feet high he is all right again. In order to land our present machines we must have a speed of at least seventy-five miles an hour to keep up our flying speed, on which depends entirely the control of the machine itself.

In our present work a man never lasts out here more than nine months before he is sent home or away for a rest, which means low flying; for continuous, daily, steady high flying appears to lay us all out physically. But all in all flying is the most pleasant branch of the service, and I am very glad that I shall never see the trenches.

I hope that what I have written may be of some use to you. I may add as postscript that the other day we had some fight, twelve of us against forty Germans. It lasted at least two hours, covered nearly fifty miles, and was mostly at 15,000 altitude. I must say that when I reached home I did not care whether my ears or my eyes or my head hurt a bit, so long as I was on Terra Firma and safe once more. Ever yours, etc., etc.

And so the letter ends, and I trust that for a few minutes it will have interested the readers of the JOURNAL and given some members of our Association some ideas and suggestions as to what care aviators need when they once more come safely to the ground and touch good Mother Earth.

J. A. S.

We have, in a previous number, given so far as was then possible an account of the promising and useful career of this younger member of our Association, but having since received further information it may here find a place upon our records.

In the original notice mention was made of the death of Lieut. Coombs as due to a fall from horseback, but as it occurred so differently from what one would suppose the accident deserves to be described more precisely.

His training was completed at the time of his accident and he was expecting to be sent across at any time. Upon the afternoon of his accident he, with another officer, started out on horseback to inspect new quarters, into which they were soon to move. They came along a gravel road at a canter, turning then upon a wet concrete road at a sharp corner. When the horses struck the slippery concrete both officers went down, but Lieut. Coombs struck on his head and sustained a fracture of the skull. He was unconscious when picked up and never regained consciousness from the time of the accident, Saturday, April 20th, until his death on Tuesday, the 23d.

He was a man fond of music and himself musical. He sang a great deal, was fond of outdoor sports, and a great reader of medical and standard literature. By his determination and skill he had obtained a lucrative prac-



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(1941)

tice, notwithstanding his youth and his brief years in medicine.

The President of the Cumberland County Society, Lieut. Sylvester, now in Markleton Hospital, also writes to us as follows: "I have especially regretted that I was not informed at the time of his identity until the body had started for Maine. I had just arrived at Camp Greenleaf and was excused from the mounted drill in which he received his fatal injury, and as he was in another battalion I did not discover until too late that he was a Maine boy, my neighbor, and a member of the county association of which I am president. I wish to add that the members of his company gave earnest testimony of his standing and popularity. It dampened the ardor amongst all of us to know that he received his death through this means and in so simple an accident, *i. e.*, the slipping of his horse as he came up out of the park on to the military concrete road when it was wet."

J. A. S.

With our present infestation with influenza it is agreeable to notice that it appeared in England with precisely the same symptoms as with us and high mortality and fell off with as great rapidity as it had originally appeared. It is useless to call it the Spanish influenza, for it has made the rounds of the world.

A clinic for parturient women suffering from syphilis has been established since last January in London and has been followed out with most encouraging results. The routine treatment for the expectant mothers has been intravenous injections of galyl and novarsenobillon before and after labor, whilst both mother and child receive intramuscular injections of mercurial cream. With few exceptions the infants gave positive Wasserman when born. This is a good suggestion for all large metropolitan centers.

In the treatment of pulmonary tuberculosis with tuberculin Thompson urges uniformity, thinks that human tuberculosis should be treated with human tuberculin, that it should not be given in cases of auto-intoxication, that tolerance should first be established by exotoxin, that inoculations should be given once a week, the maximum dose never to exceed 0.1 ccm.; that when finally reached the maximum dose should be repeated at increasing intervals.

Finally, as an instance of long-continued practice, we note the death of Dr. Marten Perry, who continued to carry on a fairly active medical practice up to the age of ninety-two. Of this personal friend of the annotator mention will be made at another date.

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County News and Notes.

AROOSTOOK.

At the last meeting of the Aroostook County Medical Society Dr. Lindley Dobson, of Presque Isle, was elected President and Dr. F. E. Dennett, Secretary.

At the next meeting of the Aroostook County Society a symposium on syphilis will be the chief item on the program, papers having been promised by Drs. Sawyer, Gilbert and Judson. Notice of the meeting will be given in due season.

Dr. Lindley Dobson, of Presque Isle, has been elected a member of the A. C. S.

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P.B.

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THE JOURNAL



Maine Medical Association.

The Official Organ of the State and County Medical Societies.

VOL. IX, No. 4

NOVEMBER, 1918.

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II
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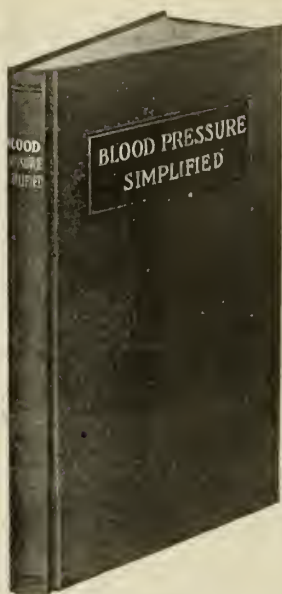
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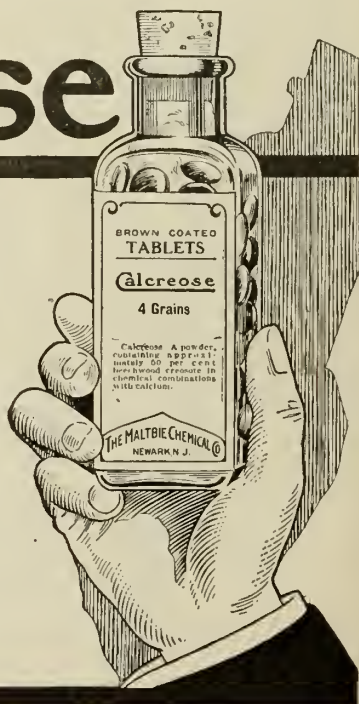
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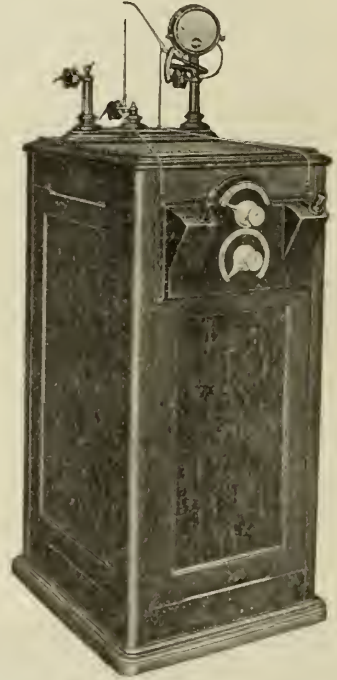
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*COMPULSORY SCHOOL PHYSICIANS IN MAINE.

By JAMES A. SPALDING, M. D., PORTLAND, MAINE.

The highest aim of medicine in any era of humanity is to prevent disease, to eradicate it when discovered, and there is no way in which this can be more successfully accomplished than by the physical examination of the school children of this nation, at an early age. Just as the farmer does not wait in his work for the complete disappearance of the winter's frost, but starts in early with the fork, and follows that up with harrow and rake, so physicians should take children of a tender age under their charge. And just as weeds will destroy the vitality of the best of seeds in the most fruitful soil, so the beginnings of disease will harry the best of children born of apparently healthy parents, if hereditary tendencies from previous generations are not early discovered and exterminated.

Most of us are compelled to make a living by trying to cure diseases which we know to be incurable, but we might hope to make a living, and a nobler one, by discovering disease before it is too late to treat with any success. In this way we would find a greater reward in the presence around us of healthy children than in gazing at costly sanatoria which only alleviate disease, or admiring expensive monuments to the memory of those whom we could not keep alive because they were too seriously affected with diseases which might have been prevented. Most of us thought, when we made typhoid from one cause a preventable disease, that we had destroyed a large portion of our incomes forever, yet we still find plenty to do with just the same

*A paper read before the Maine Medical Association, June, 1918.

typhoid, arising, however, from causes which we have not yet learned to root out. In our study now of prevention of disease we note that Maine has a law concerning school physicians, which, dull as it is, has to be printed in any paper dealing with prevention of diseases, because so few people know even of its existence.

"The superintending school committee of every city and town shall appoint one or more school physicians and shall assign one to the medical inspection of not over one thousand pupils in the public schools within its city or town and shall provide them with proper facilities for the performance of their duties as hereinafter prescribed. Provided, however, that the said committee has been so authorized by vote of the town at a regular town meeting or at a special town meeting called for that purpose. Every school physician shall make a prompt examination and diagnosis of all children referred to him as hereinafter provided, and such further examination of teachers, janitors, and school buildings as in his opinion the protection of the health of the pupils may require.

"The pupils so examined by school physicians when treatment is necessary shall not be referred to any school physician for such treatment, unless the school physician is the regular family physician of such pupil, but shall be referred to the regular family physician of such pupil through the parents or guardians.

"The superintending school committee shall cause to be referred to a school physician for examination and diagnosis, every child returning to school without a certificate from the board of health, or family physician, after absence on account of illness, or whenever in the judgment of the teacher the circumstances of the absence were such as to require such a certificate, and every child in the schools under its jurisdiction who shows signs of being in ill health or suffering from infectious or contagious diseases, unless he is at once excluded from school by the teacher; except that in case of schools in remote and isolated situations, the school committee may make such other arrangements as may best carry out the purposes of the two entire sections of the law, both inclusive.

"The superintending school committee shall cause notice of disease or defects, if any, from which a child is found to be suffering, to be sent to his parents or guardian. Whenever a child shows symptoms of smallpox, scarlet fever, measles, chicken pox, tuberculosis, diphtheria or influenza, tonsilitis, whooping cough, mumps, scabies or trachoma, he shall be sent home immediately, or as soon as proper conveyance can be found, and the board of health and superintendent of schools shall be notified.

"The superintending school committee of every city or town shall cause every child in the public schools to be separately and carefully tested and examined at least once in every school year to ascertain whether he is suffering from defective sight or hearing,* or from any disability or defect tending to prevent his receiving the full benefit of his schooling or requiring a modification of his school work in order to prevent injury to the child, or to secure the best educational results. Tests of sight and hearing shall be made by the teachers or by the school physicians. The committee shall cause notice of any defect or disability requiring treatment to be sent to the parents or guardian of the child and shall require a physical record of each child to be kept in such form as the state superintendent of the public schools shall prescribe, after consultation with the state board of health.

"The state superintendent of public schools shall prescribe, after consultation with the state board of health, the directions for tests of sight and hearing and shall prescribe and furnish to the school committee suitable rules of instruction, test cards, blanks, record books, and other useful appliances for carrying out the purposes of the six preceding sections.

"The provisions of the preceding sections shall apply only to cities and towns having a population of less than forty thousand."

Two more sections relating to dirty and contagious children, bearers of parasites or infectious diseases of the skin, mouth or eyes, have no relation to school physicians under this law, for such children are merely referred to the superintendents, who are to inform the parents, who shall cleanse the clothing and bodies, furnish the children with home or medical treatment, and keep them at home until cured, cleansed or disinfected. The last section of the law mentions the duties of parents in this last respect and fines them five or ten dollars, according to a first or repeated neglect.

Such, then, is our law, entirely optional and providing nothing for Portland. It is good, so far as it goes. If money can be found, it is carried out. A few towns spend money for this wise purpose. Portland had examiners at one time, but in a fit of economy the money once appropriated was cut off and has never been restored. I ask you, as an Association, to recommend that our Legislative Committee be instructed

* The test for hearing in some States is the whispered voice, in others a watch is used. Both tests have their value. No child, however, can be correctly tested for hearing unless each ear in turn is kept closely stopped by an assistant to the examiner, for children otherwise so tested and likewise adults loosen the pressure on the closed ear, so that some sound is admitted and defective results obtained.

to introduce a bill for an act to establish compulsory physical examination of school children as an asset for national defense.

I began this paper by saying that prevention was the aim of modern medicine. Forty per cent. of our recruits for 1917 exhibited bodily defects and were rejected. Many of these could have been of value to the nation had they as children been examined by school physicians. A vast majority of diseases and bodily defects can be cured, if detected early. Our law is good so far as it goes, yet it amounts to nothing except in the sight and hearing tests as made by the teachers. Our legislature was right in passing such a law, but wrong in making it optional. You cannot reform the people by option; you must exercise compulsion. This law, even if optional on some of the people, ought not to be denied *in toto* to Portland. You cannot grant rights to some of the people and not to all.

Now then, somebody asks me: "Will you make it plain why we need compulsory examinations of school children?" We need to make an examination of all children so that as they grow up we can know just where, in time of war, to look for healthy adults, for young men to be soldiers, sailors, aviators, or to work on farms, or to build ships, and for young women to work on farms, on aeroplanes and in munition factories. We need a physical census of every person arriving at age, forever. By such a census you can not only find your soldiers and sailors, your farmers and your munition workers, but you can keep track of the slackers and make them toe the mark, because you have their record up to the time they left school, and if healthy then, they are likely to be healthy to the age for national service.

My first reason, then, for compulsory examinations is, that we may obtain a census of the physical ability of the state, as our quota of a national asset for defense in war.

The second reason is, to discover tuberculosis and other diseases at an early and preventable age.

Maine rejoices in a fine sanatorium for the cure of tuberculosis. Some of the patients there, as also in private institutions, are cured or relieved, some continue incurable, and many die before the span of life allotted to them by their Creator. I believe that the proportion of cures has not manifestly increased since sanatoria were founded. About as many people die of tuberculosis as died a century ago. They die more comfortably, perhaps. Their condition has been improved, and their surroundings greatly, but practically, yet tuberculosis remains a scourge. Are we on the right road to rid ourselves of this disease by taking even the best of care of those who suffer from it, whilst we deny to common sense a share in trying to find a better way out of our

dilemma? What would it cost for school examiners in every town to discover and treat tuberculosis in children, in comparison with endless money spent in vain efforts to try to cure it in a stage altogether too late? This question should therefore be studied financially and medically, and from the standpoint of hope to eradicate tuberculosis. A skilled physician with children passing before his desk could almost at a glance discover incipient tuberculosis upon their very faces, as in lips, nostrils, eyes, running ears, teeth, enlarged glands and so on.

My second reason, I repeat, for school examiners is that with their skill tuberculosis, for one disease, could be discovered, segregated, and treated with hopes for a cure.

A third argument in favor of compulsory school examinations is that in that way we could discover the defectives, the feeble minded, the intractables, the truants, and drill them into shape. How many of us ever think of the giant strides which juvenile delinquency is making amongst us? Every nation complains of juvenile crimes. The City of New York had 5,000 cases in 1916 and over 7,000 in 1917. England, France, Holland, and even far-off Sweden, suffer in the same way. The darkening of the streets at night, the spirit of adventure, the open gambling machines, the unguarded transportation of goods along the public highways, the love of finery, and of looting; all have contributed to these crimes of childhood. And as for Germany, what shall we think of mere boys killing with his own bottles the driver of a beer cart, so that they could then get drunk! Imagine a young girl killing her sister to get at her saved-up wages. Recall two sisters invading for plunder a supposed unguarded home, finding to their surprise the woman still in charge, killing her with tongs and shovel, and then deliberately murdering four mere children to prevent their being living witnesses of the crime. Endless are the instances of crime in Germany of to-day, and endless is it becoming everywhere. Look at our own prostitution of young girls, the pilfering of money in our homes, and the \$100 pocket-book robbery of yesterday, and what else is this poisoning of dogs of which we hear than a plan to get rid of the guardians of property. Consider our truants, and you find most of them defectives. They don't see or hear well, they have crossed eyes or a physical scar or a defect which they hate to show to the other children, and so they play truant and drift into juvenile delinquency. In the schools, I assert, we can discover the defectives, the stubborn, the incipient juvenile delinquents, and try at least to put them straight.

Thus ends a third reason for school examinations, and I repeat them: as a national asset for defense, as an attempt to get rid of tuberculosis, as an obstacle to juvenile delinquency. The list might be

prolonged, but these three reasons ought to suffice to compel every thinking physician to do his very best to help out the nation by favoring the plan and agreeing to do his share of the work at a reasonable rate in the towns in which he lives.

"Please do not finish your paper without telling us your idea in which such examinations should be made," I hear someone say, and here it is. I would follow the suggestions of my friend, Dr. Deering, of Worcester, Massachusetts, who was born in Gorham, lived in Portland, and who has had much experience in this work.

Teachers, scholars and examiners are provided with their proper cards, the wording, shape and material of which can ultimately be agreed upon by conferences with the State Superintendent of Schools. On a certain day the teacher is informed that the examinations will begin. The examiner comes, stands or sits near a desk, with a window behind him to give good light. The children file along, and each one is tested with the stethoscope, three heart beats being noted. If nothing wrong is heard, each passes along to his seat. If anything suspicious is noted, the child is directed by a mark on his card to report later at the school office. When the heart test is finished the children lay their hands on their desks, and each one is examined for signs of a skin affection, or for rickets.

The children now approach the table once more, card in hand, and as they come into the strong light of the window, the examiner notes the skin of the face, bunches in the neck, the use of glasses, any blepharitis, conjunctivitis, styes, cold in the head, swollen nostrils, mouth-breathing, possible adenoids, fractures or injuries. Sight and touch are then utilized for anæmia and nutrition. Anæmia is judged by the looks of the everted conjunctiva, or lips, nutrition is decided by the feel of the upper right arm by the examiner's left hand. The mouth is next opened, teeth inspected, tongue depressed with a special spatula for each child, and the tongue, tonsils and naso-pharynx inspected and adenoids looked for. Finally, with the spatula, the hair is raised to discover any pediculosis. After examining the left side of the neck first for swollen glands, and then the right, the child passes along to his seat.

Any list of defective children previously made by the teacher is handed to the examiner, who goes to the school office, more careful final examinations are made, and the teacher or parents advised by card just what to do for the child.

No questions are asked of any child but sight, touch, hearing and smell, and the teachers' previous suggestions, based on ordinary daily observation, are the points relied upon throughout.

In this way some 1,400 children were examined in five hours. It is not a perfect way, but it is the beginning for a better. It is rapid, it is comparatively thorough, and the time lost by each child from school work is hardly more than five minutes once a year.

The children are never stripped. Hernia, of course, cannot be discovered by such superficial examinations, but the parents will, in case of doubt, have to be consulted first.

Parents should be invited to see just what a school medical examination actually is. If they found nothing against which to object, they would the more gladly vote for the costs to the town. England's experience, as I hear from a friend over there, has been, that few parents ever want to attend, even when cordially invited. They leave it to the doctors, who know best.

Women physicians, and nurses also, should be employed in this work, and their special labors could be defined by experience.

Somebody will be sure to ask the cost of all this work. Florida thinks that eighty inspectors would be needed at a cost of \$80,000 for her 200,000 children. This is, however, not my idea at all. Let the teachers test the sight and the hearing as of old, if they wish to. It adds to their work in one way, but it lightens it in another, by sparing useless efforts to try to teach children with defective sight or hearing. I would not have special school examiners, for every town contains physicians of ability. Once started to work, their skill would increase. I would have the one physician in the town work for a special sum. If there were two, the work should be divided. If three or more, they should be advised by the County president how to divide the work and the pay amongst each other, one year one doing it, and so on. In larger places physicians could come from a school district or a ward in a city. Money isn't everything to a doctor. He gets acquaintance in doing such work, which is better than money. Let the physicians remember that much school work has been done in time past gratuitously by many a doctor, and that we all must bear the national burden in various ways. Massachusetts has special examiners, but many of them are the only physicians in the town. The pay in some 215 districts is \$100 or less, in many instances \$50. In cities the pay is higher, as full time goes to the work.

School physicians could also speak on personal cleanliness, amongst other items, of washing the hands before eating. Only think of it, that the raggedest, dirtiest looking Mohammedan in the world would never think of eating a morsel of food without washing and drying his hands for fear of contamination. How few of those whom we regard as civilized ever think of this! I would have the examiners

also emphasize individual cups, hair brushes, towels, and basins and soap. Most of all should they urge the care of the bowels. Old Dr. Hiram Hovey Hill, of Augusta, said a long time ago: "Every child should be taught to look behind, and see that he has passed out of his bowels every morning a good sized banana, and not a whole lot of little walnuts."

In the midst of war, such a paper as this may seem out of place, but war does not last forever. When peace comes we must get ready for stirring times ahead, and I know of no better way than to make a good catalog of our children. Public interest is, however, small. A paper precisely like this was offered to the newspapers in Maine, but nobody would print it, because "the children are tested already under our excellent law, and provided with cards." Yes, indeed, but how few of them knew that our law for such tests was of no use at all, because the law was optional, and the examination made only of the sight and hearing, as if to see and to hear were all the world to all of us. Did they never think that we are here also to do something with our bodies, if they are tested and founded capable of work for the nation?

CHAIRMAN COOMBS: Dr. A. O. Thomas, State Superintendent of Schools, is invited to open the discussion.

DR. THOMAS: Mr. Chairman, and Members of the Society: I am very glad to come here and discuss with you this vital subject. I presume it would be in order to pay something of a tribute to the profession which you represent for the work you have done. No class of workers in the country has worked so unselfishly as you, and the voluntary researches in science have resulted in marvelous results in connection with the war. We stand in admiration of the science which can take these fragments of men, as we find them in connection with the battlefields, and do so much for them as has been done in connection with this great world war.

I am interested in this paper presented by Dr. Spalding, because it is on a very vital subject in connection with the schools. I hardly know where to begin the discussion. I hardly know what to say and what to leave unsaid. I presume there is no difference of opinion among those present in regard to the importance of medical inspection. I presume there is not a physician in the State of Maine who would not welcome some kind of a scheme which would be effective in connection with this. The doctor has covered the field very well, but we are moving very rapidly, and I see greater hope ahead than I have ever seen; I see it in tangible form today. Sometimes we are forced to do things we ought to do, and the war is forcing us to do some things which we ought to have done generations ago. War reveals the weakness of the people, and we are going to do something now that we have not done before. The conventionalities of the past must be placed on the shelf. We are now doing things, startling things, things we did not dream ten years ago could be done; and I have on my office desk the copy of a bill which is already drawn and with which I have had something to do. Some four or five years ago, and on down to the present, and

until the beginning of the last year, I was the lone advocate of it, almost, in the United States. That bill is drawn ready to be presented to Congress, and it has the pledge of the Education Committee of the House, and of Senator Hoke Smith, Chairman of the Education Committee of the Senate. They want the bill got ready to introduce and back it, and they have assurances from their fellows in Congress that the measure will pass. This measure appropriates an immense sum of money, \$100,000,000, for educational purposes. A percentage of this is to relieve illiteracy in the United States, where we have six and one-half millions of people who are illiterate, one and one-half millions of those being native born white people between the ages of twenty-one and thirty-five; and so they feel that it is necessary for democracy to wipe it out, and the measure carries a portion of this appropriation for that purpose. It carries one-fifth of the \$100,000,000 for medical examination in schools—physical education and the school nurse—and that sum of money ought to be efficient in its results in the schools of our country. We talk about democracy and the rights of the people, and the people of Maine have held very tenaciously to their rights; and when this measure, which is now a law and on the statutes of our State, was introduced and presented to the legislature, it could not have been passed in any other form, because the people insisted upon their rights to say whether or not their children should be examined by any person selected by others than themselves. So the matter became a law in that form. It has been used in the State to some extent. There are some fifteen or twenty towns in which the examinations are carried out, in many instances inefficiently, not reaching the result that they should. Again, in many instances they are doing their part; in many instances the physicians are giving their time. In Rumford last year the physicians gave their time and parcelled out the work—the men who treat the eye and the ear, with the general practitioner, made their examinations—and this is done in some other towns in the State.

It may be interesting to you to know that the week beginning the eighth of July, we shall call together all of the superintendents of schools of the State, 140 in number. Up until the first of July of this year we are having in the neighborhood of 350 superintendents. After the first of July the new system goes into operation in this State, and makes 140 people responsible for the local communities, for the administration of the law and the development of the schools, and these 140 men and women will be called together for a conference, and these matters which are now so vital to the progress of our schools and our people are to be taken up, including the questions of medical examination, of health conditions and of truancy.

Now it will be necessary for the States to meet the requirements of the federal government on this appropriation of federal money. The bill calls for this to go into effect the fourth of next March. The men who have it in charge in Congress say that the bill is likely to pass. It will bring to the State of Maine practically \$750,000 of the federal appropriation. In order to get its quota, it must meet the requirements of the Federal government. The Federal government will establish the requirements of medical inspection. If mere medical inspection is not sufficient, there must be measures taken to correct all the physical troubles which we find in connection with these schools. The future of America is in the schools today; 22,500,000 of our future citizens are in the schools. I do not know why we should not have medical inspection of individuals. I do not know why the physician who presides when the child is ushered into the world

should not make a thorough examination, or possibly very soon after. I do not know why this should not be a requirement and a registration made of its condition. I do not know why that method could not be followed out. I do not know why we should simply accept the situation when a child comes to school and is made a school child, inspecting them as they are congregated together. I believe we should begin earlier. This registration which is being promoted by the Child Labor Department, or Bureau of the Labor Department of the United States, to save out of the 300,000 infants which we lose each year in the United States 100,000 of them in order to replace the 100,000 it is estimated we shall lose across the sea. It is the conservation of human power and human ability. As a teacher in school, I have not determined many instances of children physically defective who cannot make progress. We find defective children in every community. Many defects are not serious if taken in hand. Defective teeth, mouth breathing, defective hearing, adenoids—all these materially affect the progress of the child in his class. He grows dull when he may be naturally bright. It may not be the fault of his parentage; he may start all right; environment may not affect him. We see it in children going through school without treatment, when such treatment would change that child from what we term an abnormal child to a normal child, and help him to make normal progress in his work, sending him out into the world as a bright citizen rather than a stupid one.

The questions of medical examination and medical treatment go together. We are building new schoolhouses today; we have new ideas. Every schoolhouse of considerable proportions in populous communities should have its nurse, it should have its first aid to the injured, it should have the means of treating the physical defects of the children. Then there should be something back of it to force the treatment that is necessary.

And now comes the old question which is for us to settle, because we are going to have the medical inspection in the future, regardless of the fact that there are considerable forces lined up against it, saying that we are taking away their rights, that their religion does not approve of it, that they are going to see whether or not they shall have treatment, that they do not believe in medical treatment, anyway. Regardless of that, the federal government now sees that the conservation of the human element is the greatest problem of the age, and that the future of America must be strong. Therefore, this question of medical inspection, and then medical treatment, and then physical education on top of that, is something the United States Government is interested in. The United States Government has entrusted the States of the Union to arrange their own educational systems. We have forty-eight different educational systems in America and no national system. The States have taxed themselves directly and paid their bills. The United States Government raises its money by indirect taxation, and is proving itself to be the greatest money-raising machine, the greatest financial machine, on earth, and from the 28th day of last March down to the 14th day of October, it appropriated within six billions of dollars as much money as was used in the United States from the time of their inception down to that date, more than 140 years, for the building of the Panama Canal, the support of the government, the support of the army and the navy, the building of battleships and the building of roads. Now the State takes the child, while citizenship accrues to the government. The child does not throw up his head and say, "I am a citizen of Massachusetts, or of Maine, or of Kentucky," but he says, "I am an American citizen," and he prides himself on it, and the

United States puts his hand on his shoulder and says, "I want you to fight in my trenches," and he finds it necessary to take a hand in the matter of conserving this human element. These young men must be finally fitted to fight in the trenches in the future. Physical education must extend to all alike. Therefore the United States Government says the State that receives this money must come up to its standard. These things must be done in the larger element of service to the country and the common good. The individual right ceases when the group interest begins. We have put this off too long. I am in favor of the conservation of this human element, of making the race strong, because if it is going to be the survival of the fittest in the government of this country, America must begin now. We are beginning a generation or two too late. We cannot correct the vices of the past, but we cannot begin too soon to make strong the generations of the future, to conserve the physical foundation for the strong civilization America must have. I presume there is no question about that. Then comes not only medical inspection, but there comes in the teaching of physical education and development. Then the school nurse comes in, and I think, Mr. President, that the school nurse will be one of the most vital factors in connection with the schools of the future. The children will come in, and she will be the one who will discover in a large measure the little defects that might escape the casual examination, defects that show up in the intimacy of life, and she will help them.

The question of truancy must be dealt with in another manner, and that is, we must eliminate the illiteracy and the shiftlessness. Last year the truancy list of the entire State was less than 1,000. Many of those were living in remote sections; but from the census rolls there were only 1900 on the compulsory education list that were not in school, and half of those were excused.

One thing I want to say to you in which I am interested, and I want you to carry it to your homes, and that is that we are trying to keep our schools carrying on, that education is as vital today as fighting in the trenches. The United States is needing educated men and women, and they ask that the young men be left in the schools until they have prepared themselves, for if we raise five millions of men, as we probably will if the war lasts four or five years, as is very likely, there will be three or four classes of young men coming in ready to be drafted. The United States is interested in that group of reserves and wants them kept strong. It is going to make provision now in the colleges of this State and other States to inspect these young men, give them medical treatment and physical education, and fit them not only for military service, but for the hundreds of army vocations. Here is where the government is stepping in, not with the little children, but with those going to the colleges, and giving them medical inspection, which is good in itself, but which does not go far enough yet; but the rest will follow as a matter of course. (Applause.)

CHAIRMAN COOMBS: We are certainly very grateful to Dr. Thomas for giving to us from the standpoint of a trained educator his views on this most important subject.

At the suggestion of the Chairman, the thanks of the Association were expressed to Dr. Thomas by a rising vote.

CHAIRMAN COOMBS: The paper is open for further discussion.

DR. B. W. MOULTON: Mr. President, I wish to rise and heartily congratulate our President on his paper. I wish to say that I have been a school physician for

two or three years in the town where I am located, and I think there will be no need of a legal process to bring this about if the towns only once start. I have yet to find a parent who is not disappointed if his child is not there when I visit the schools. The ways in which this examination should be conducted I presume are numerous; but I have verified a few in my own way according to my own location. At the present time I have about 400 pupils to examine, and many things brought out during this examination are such that they would certainly affect the future welfare of the pupil. I wish to say this, no one should refuse to become a school physician, because it is interesting even if it is not financially a success. The towns pay me but very little, but I get enough out of it to make it interesting, and I certainly hope to see it carried out in every community. The various ways in which one should carry out this examination, of course, are up to the individual. I have some of my own.

DR. NORTON: Mr. President, I think we are all agreed as to the desirability of action in regard to the medical inspection of schools. I have had this idea for a great many years, and it was partly through my influence, and partly through the influence of members of the School Board of Lewiston, that I became one of the first medical examiners in New England, I think, having examined the eyes and ears of the pupils of the Lewiston schools as long ago as 1882. Since that time I have observed certain things that point out the difficulties of enforcing the law. You may make a good law, but if the people are not favorably inclined towards it, it is very difficult to enforce it. I found at that time, and I have since found, that some of our educators were opposed to the idea, and this may be illustrated by referring to a grammar school teacher in Lewiston, who buttonholed me and said, "Doctor, you will probably find a good many defects in the pupils of our schools, but do not say anything about them." He said, "There is altogether too much criticism of the schools at present," and he tried to prevent my giving a truthful statement to the Board that appointed me. Another class that is opposed to this are the parents. A man who is a judge of a municipal court absolutely and positively refused to have his daughter's eyes examined, although her eyes were defective, as afterwards was found out, and she was suffering from eye trouble at that time. That man refused to have proper treatment for his own eyes, saying that the oculist could not be trusted to express a true opinion in regard to them. I have known two Superintendents of Schools in the State of Maine who were very much opposed to this school inspection. I have known one State Superintendent of Schools, who, though I never heard him express his opinion, yet his action indicated that he had no interest in it. At least, a section of this Association presented the subject to him, and we offered him our assistance, and when the time came when we were expecting to assist him, not one word came from him, and I know by his action that he was really opposed to the idea of the State inspection of schools.

There is another point that the educators are unwilling to admit, although it was pointed out as long ago as 1864 that the schools injured the eyes of the pupils. Now they have studied very carefully, and have made great progress in showing how education may be promoted by attention to the pupils' eyes, but they have not given as much attention to the question of how the pupils' eyes may be conserved—the pupils' vision—and their health conserved by proper school methods. Now as a way to accomplish this purpose, I believe that in every school we should have—in the high schools—instruction in hygiene, and of course

I may be prejudiced, but I think emphatic instruction in the hygiene of the eyes and ears. Now what good is this going to do? Why, these high school pupils in a few years will be the parents of children that they send to the schools. Now we can accomplish a great deal in that respect.

DR. SPALDING: If nobody else wishes to say anything, I will speak for one moment in regard to this card which I have made up as a composite card from every nation in the world that examines its children, and it covers every ground that one can possibly imagine. A card like that contains a special note to the examiner what to look after, and a card of that size makes a good record for every child in Maine. It might be made a little smaller, a little bit more solid, but that is a very good card. This card I intend to hand into the legislature in due season, and, with the School Superintendent, I hope that we shall make some progress in regard to it. I am glad the discussion of the paper proved of value. It opens new ideas and trains of thought, and I hope it will be carried through successfully at the legislature.

SPOROTRICHOSIS—REPORT OF A CASE.

BY DONALD B. CRAGIN, M. D., F. A. C. S., Waterville;

THEODORE E. HARDY, A. M., M. D., Waterville;

JOHN F. SHAW, M. B., Central Maine Sanatorium, Fairfield.

CASE No. 802.—Frank D., age 22, surveyor, single. Family history negative. Apparent good health up to May, 1917. Appendectomy May 15, 1917. In July, 1917, abscess developed in left cheek, followed by one over thyroid. Admitted to sanatorium March 3, 1918, with a diagnosis of tuberculosis of the lungs and lupus, complaining of loss of weight and strength, slight dyspnoea, cough and expectoration. On examination left cheek showed discharging sinus, surrounded by a mass of indurated tissue. Over thyroid, discharging sinus with same characteristics. Discharge thick and yellowish. Chest—Heart normal. Lungs—Fine discreet moist rales throughout right upper lobe. Abdomen—Fæcal fistula from appendectomy. General bulging abdominal wall on coughing, apparently due to atonic condition of muscles. Right leg shows hard swelling beneath calf muscles, slightly red over area. Successive sputum examinations were negative. Urine, blood and Wasserman tests negative.

On admission patient's temperature ranged from 97 A. M. to 99.8 P. M. Shortly after temperature ran typically septic course, after-

noon temperature going as high as 102.6. Acute pain developed in right leg and abscess was incised, resulting in the evacuation of about six ounces of cheesy material and viscid yellow homogeneous pus. A specimen was obtained and sent to the laboratory of the State Board of Health for special culture. Tentative diagnosis of sporotrichosis made at this time from the intramuscular abscesses, indolence of lesions, lack of response to surgical treatment, the viscid, grey-yellow, homogeneous pus, swollen margins and crateriform character of lesions, combined with a fair measure of good health. While waiting for the report from the laboratory of the State Board of Health intensive iodide treatment was carried out, and all lesions, including faecal fistula, showed marked improvement promptly, apparently confirming diagnosis therapeutically. The report from the laboratory of the State Board of Health was no growth for the first two specimens submitted, but the third, grown out on Sabouraud's peptone-glucose agar, showed the characteristic filaments with true branching and spores.

All lesions are apparently healed at this writing except that of the lung, which, however, shows marked improvement. The patient has gained thirty-three pounds in weight and feels well.

Case No. 802 was first seen by one of us May 15, 1917. At that time he had a large pelvic abscess from rupture of a gangrenous appendix. The pus from the appendix wound was of the same character as that described above, and we are of the opinion that the initial lesion was due to the same organism later found in the discharge from other wounds.

CLASSIFICATION OF PHYSICIANS TO DATE.

We have received from the Council of National Defence a complete account of the classification of physicians up to October 1st, and it may be condensed into this practical shape for ready reference.

Interest in the members of the profession as to how their services are to be used in the Volunteer Medical Service Corps after they have been enrolled and have put on the badge has led to the basic system of classification for the organization as a whole.

Class I contains physicians first recommended for commissions in the Medical Reserve Corps of the Army, Reserve Corps of the Navy, or public health appointments. This includes physicians under fifty-five without obvious physical disability, and who have not more than one dependent in addition to themselves, or who have an income, or whose dependents have an income, sufficient for support of dependents, other than that derived from their practice.

Under this class there are exceptions, such as being needed in the community, needed by any institution, needed by the health department or essential to a medical school, or on its local or medical advisory board. All of these exceptions are determined upon by conferences of various boards.

Class II contains physicians under fifty-five without obvious disqualifying physical disability, and who have not more than three dependents in addition to themselves. These will be recommended to apply for commissions.

The exceptions to this class are the same as to Class I.

Class III, physicians under fifty-five without physical disqualifying disability, but with more than three dependents, and they are the physicians excepted under Class I and II. They will be recommended for commissions in great emergencies only.

Class IV includes those ineligible for commissions, but available for other services. They are all over fifty-five, or physically disqualified or previously rejected for disability. Physicians not professionally eligible will be recorded but not admitted to the Volunteer Medical Service Corps.

Applications for enrollment in the Volunteer Medical Service Corps continue rapidly, and they are being classified as quickly as possible.

State Executive Committees to care for the Volunteer Medical Service Corps are organizing everywhere, and county representatives have been appointed in practically every county in the nation.

It would be agreeable to many who have already enrolled in the Volunteer Corps to have their work more precisely defined, and of it we shall undoubtedly have information in due season. If, however, such duties were quickly suggested and tabulated the response to the call for the V. M. S. Corps would undoubtedly be greatly accelerated.

Necrology.

WILLIAM PETER McNALLY.

BANGOR.

Peter is a very attractive name for a boy, and if he lives up to the traditions of the name he becomes a man well worth knowing. It is true that our late comrade, William Peter McNally, of Bangor, was not often called by the name of Peter, but he should have been, judging from all that I knew about him from occasional meetings, and from all that we have otherwise heard about his career.



Family history tells us that he was born September 3, 1865, at Egmont Bay, Prince Edward Island, the son of John and Julianna McNally, that he was educated in the public schools, and afterwards at the Prince of Wales College and at St. Dunstan's College in the island of his birth. He seems then to have spent some years as a teacher of French in the provincial schools. Finally medicine attracted him, and after four years of study at the McGill University Medical School he obtained there his degree in 1897, being then about thirty-two years of age, rather older than most beginning practitioners of the healing art. The authorities at McGill inform us that he bore there the reputation of a very steady and conscientious student of medicine and materia medica rather than of surgery, which at that time, however, was not so much the aim of students as it is to-day.

Dr. McNally settled almost immediately in Bangor, married Miss Margaret Ellen Daly, of Montreal, in 1900, and continued in the practice of medicine until his death, Tuesday, April 30, 1918, being then about fifty-one, too early by many a year.

McNally was a big man, with a big heart and kindly nature, one in whom people put confidence, and they found that it was never misplaced. You liked him when you first met him, and you liked him ever after. His personal presence charmed away the bogies of affliction, pain and disease. You felt that he could pull you out of a hole if anybody could. He was clever at diagnosis, and seemed to understand just what a medicine would do and what could not be expected from its use. He was a man overflowing with personal attraction and bonhomie.

There is a picture of Dr. McNally somewhere, showing him under the shimmering light of trees in a garden, and from it the half-tone here was made, and when you saw the picture of the big figure coming toward you, as it were, you seemed to feel as if you must go forward to greet it yourself.

About the best medical paper from the pen of our friend was one on "Some Aspects of Renal Disease," which justly hit the mark, whilst in the discussion of papers by others he excelled. Amongst his public positions mention may be made of his presidency of the Penobscot County Medical Society, consulting physician for several years at the Eastern Maine General Hospital, and instructor and lecturer to the tuberculosis class at Bangor from its start. As a man he was steadfast and reliable, much respected, admired and looked up to by his fellow men. He was a man also of deep religious feelings. He retained to the last his wonderful exuberance for outdoor sports, was fond of the game and of college sports, and liked to see the young people keeping up the sporting traditions in which he had been educated.

The departure of Dr. McNally from the medical ranks of Maine occurred in this wise. He worked too hard at his practice in the early spring of 1918, got a bit better pretty soon, but plunged in again head over heels, with the result of a very serious attack of pneumonia, from which he died April 20th, very suddenly.

At the annual meeting of the House of Delegates of the Maine Medical Association in June, resolutions concerning the early and untimely death of our very genial associate were passed, and the President was directed unanimously to express to the widow and bereaved daughters the extreme regret of the Association, with which he had been so kindly associated for so many years as a very prominent member. This was duly carried out at once, and as necrologist of the Association I beg leave now to add these few sympathetic notes concerning our late and lamented member and friend. He was indeed a man to be admired, respected and esteemed as a comrade in medicine.

J. A. S.

Foreign Notes.

SKIN INK FOR RADIOLOGISTS.

A good deal of trouble has been experienced by ray men owing to nurses and others insisting on scrubbing away ink marks purposely made on the body to localize fractures, tumors and so on. A good formula for ink that can't be in this manner erased can be made from pyrogallic acid, 1 gr., spirits vini menthol, 10 c. cm., liquor ferri perchloridi fort., 2 c. cm., acetone added to 20 c. cm. Keep it in a bottle with the brush affixed to the cork. When first applied it is brown, but soon changes to black. It will, however, ultimately wear off, so as not to be a perpetual grievance to the patient.

LEFT-HANDED RECONSTRUCTION.

Urso, of Rome, has published a monograph for teaching left-handed soldiers how to write when the right arm has been amputated. His idea is that the left-handed can only be taught properly by first standing at a blackboard and making the letters with chalk. Let them write from the shoulder and elbow, the wrist and fingers being immobile. Later on let them try the pencil, and last of all ink. The copy books should be placed on the desk so that with the light from the right hand all letters are written vertically. Then when the book lies straight across the desk the writing has a proper slope. Those who happen to be interested in the rehabilitation of soldiers who have lost a right arm previously used for writing will find valuable details of Urso's method in the *British Medical* of January 1, 1918, page 16.

IS PURGATION NEEDED BEFORE OPERATIONS?

Those who do not read a paper by Alvarez in the June number of the *Journal of Surgery, Gynecology and Obstetrics* will miss some new ideas. Fearing that some of our readers may not have seen the paper, we print here the conclusions of the writer.

Purgation before operation is unjustifiable for these reasons, that there is no need to fear self-intoxication from clogged-up bowels, nor gas pains, nor peritonitis. After many animal experiments the author decides that some purgatives irritate more than they do good and interfere with intestinal absorption. Dehydration of the body before operation is bad. With some patients there is more fluid in the bowels than is wanted by those looking for an empty bowel. Purgatives produce an increase in bacteria, increased absorption of toxins, and

undigested food may by their use be carried into the colon to increase the pabulum on which bacteria flourish.

Some parts of the bowel are weakened by purgatives, others irritated. Flatulence and distention may follow purgation. If there happens to be an intestinal obstruction the purgative may kill the patient. Purgatives tend toward bowel reaction, exciting serious difficulties in post-operative emergencies, whilst finally post-operative nausea may have as its single cause the use of purgatives previous to the operation.

This brief abstract gives but a slight idea of the points of a most attractive surgical paper well worth reading in full in the original.

VAGINAL DOUCHING.

Rather late in the day, indeed, do we call attention to a very vigorous paper by Fothergill in the *British Medical* for April 20, in which he lays down the law that the invention of the vaginal douche has been a curse to women rather than any sort of a blessing. As we had the pessary era we have the douching era. Versions and flexions went out of fashion, and endometritis and ovaritis came in. Great attention was given to vaginal infection, regardless of the fact that the vagina was rarely if ever infected at all. It was the fashion to wash out the vagina before, during and after labor. Simpson ordered Fothergill, as far back as 1895, to tear down from the ward walls of the Edinburgh Maternity all instructions for vaginal douching, which had been in force for years, during which period more than once the hospital was forcibly closed on account of epidemics of puerperal pelvic infections.



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The public got hold of vaginal douching, and Fothergill instances a woman who began with a douche at nineteen and kept it up daily to the age of forty-five. Her vulva, vagina and cervix are now raw and streaming with discharges. Every patient complaining of minor pelvic ailments should be asked if she douches, and if so it should cease at once. Nurses often douche without any orders. The vagina has no glands, and most vaginal infections cure spontaneously, if left alone. The doucher never gets rid of her vaginal discharge, and gets other complaints additionally. Dry clean the vagina if you must, but do not douche it. If gonorrhœa is present the douche simply drives the infection into the uterus. Palliative douching in cancer is justifiable if done occasionally. Hot douches, if ordered, mean hot (120°) and not warm fluids. Do not let any patient douche herself, even if you think that she needs that sort of care. And, above all, do not use aseptic douches unless there are germs to be destroyed. Vulvitis is common, vaginitis is rare. If a patient has vulvitis let her sit in a bowl for lavage, but do not allow her to douche herself nor let a nurse douche her; do it yourself when absolutely indispensable.

MERCURY IN OPTIC ATROPHY.

Suker, starting out with the belief that optic atrophy in tabes and general paralysis is incurable by any remedy yet devised or used, recommends, after many animal experiments, that an effort should be made for a cure by lateral ventricular injections of bichloride of mercury. These should be made by needle introduced on the right side of the brain into the right lateral ventricle, so as to damage as little as possible any of the functioning brain centres. Care must be taken also not to puncture any large dural vessels. The various details of this curious experimentation, with asserted results, were lately printed in the *Illinois Medical Journal* for June, 1918.

It is very apparent to the careful reader of this annotation that immense care would be needed in order to carry out this procedure skillfully and without danger to the patient. One would wonder also if similar injections into the spinal canals would not effect the same results.

VALUE OF X-RAYS IN DECIDING THE AGE OF THE FOETUS IN UTERO.

A very attractive paper, with skiagrams, in the *Illinois Medical Journal* for May last, by Dr. Hess, points out the value of the X-rays in determining the age of the foetus in utero. The idea of the paper is in this way to determine the viability of the infant and to save, if possible, one which might be born prematurely. Starting from fixa-

Furunculosis

FIFTEEN cases of boils and carbuncles were cured by yeast treatment, out of a total of sixteen cases of obstinate character! A case of styne promptly yielded—the cure being very rapid.

These tests formed part of an investigation of compressed yeast as a therapeutic agent, made at the Jefferson Medical College, the Philadelphia General Hospital, and the New York Roosevelt Hospital, and reported by Philip B. Hawk, Ph. D. (Journal A.M.A. Vol. LXIX. No. 15).

"In furunculosis," the report states, "yeast is a remarkably efficacious remedy. Its curative action in these cases is no doubt aided by the leukocytosis which developed."

FLEISCHMANN'S COMPRESSED YEAST, which is put up and sold in the familiar tinfoil package at grocery stores, and used by the housewife in making bread, was used. It is a scientifically cultured yeast, being of the species *Saccharomyces Cerevisiae*, and is of uniform strength.

Three cakes daily, between meals, was the usual dosage administered, in a suspension of water, fruit juices or milk.

This yeast may be secured fresh daily in most grocery stores. Or, write the Fleischmann Company in the nearest large city, and it will be mailed direct on days wanted.

A reprint of Dr. Hawk's report, with added matter on the production of the yeast, has been distributed to physicians. If not in your files, a copy may be had upon request.

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tion of the time of conception, the writer notes the length of the fœtus, shows skiagrams of normal development at various weeks and months of life, discusses the limitations of accuracy in these respects, different values of different portions of the body, and urges the value of repeated skiagrams as superior to any other modes of measurement. The paper then goes on to show the best ways in which to take the pictures, and emphasizes the endeavor to make the best of one exposure, if only one is to be available in studying that special case. He concludes that the stage of ossification as seen in the skiagrams is of practical importance in determining the age of the fœtus; that skiagrams are more trustworthy than other means of measurement, because the bony development is more regular than the mere size; offers more points for consideration; one part of the body is a better criterion for others, and that pathological changes can also be recognized. Finally, in the early months of pregnancy, so far as skiagrams are concerned, more accuracy is possible than in the later.

HEALTH LEAFLETS.

The State Board of Health has sent out a large number of leaflets on the influenza, particularly emphasizing quarantine. To this we add the emphasis which a physician has handed in to us concerning the virulence and infectiousness and contagious types in some parts of Maine. The Board, we are also very glad to know, intends soon to send out a bulletin containing special information concerning venereal diseases control. This bulletin, we are sure, will be gladly welcomed by all physicians, many of whom still remain in doubt concerning the value of modern treatment, and particularly the precise means of notifications needed for forcible and effectual control.

PERSONAL NEWS AND NOTES.

We regret to announce the sudden death of Dr. W. S. Thompson, of Standish, Oct. 1st, at his home, from acute indigestion. Notice of his medical career will appear from the pen of the Association necrologist in due season.

The October meeting of the Aroostook County Medical Society, called for the first week in October, had to be postponed, owing to the prevalence of influenza and the considerable number of physicians consequently unable to attend. We are informed that the proportion of cases of pneumonia associated with the present epidemic is very large in the Aroostook region, and the mortality considerable.

We regret to announce the death from pneumonia on the 20th of

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October of a very capable member of the Association, Dr. Joseph W. H. Porter, of Caribou. His death is to be attributed solely to overwork and sacrifice to the needs of the people stricken with the grippe.

We are very glad to note that Lieut. C. B. Sylvester, M. C., has been recommended for promotion for excellent service and meritorious work in connection with tuberculous recruits, and has now obtained the rank of captain. We wish continued good fortune to the President of the Cumberland County Medical Society, who is for this year no less than Capt. Sylvester, of Harrison.

In a recent note from Capt. C. B. Sylvester, M. C., of Harrison, now in service at Markleton Base Hospital, Pennsylvania, he informs us of the curious fact that although many of the patients there are suffering bitterly from the influenza, those previously infected with tuberculosis remain very largely unaffected and immune to the prevailing epidemic. Capt. Sylvester is studying this aspect of the epidemic, and if items of value are discovered they shall be given in due season in the JOURNAL.

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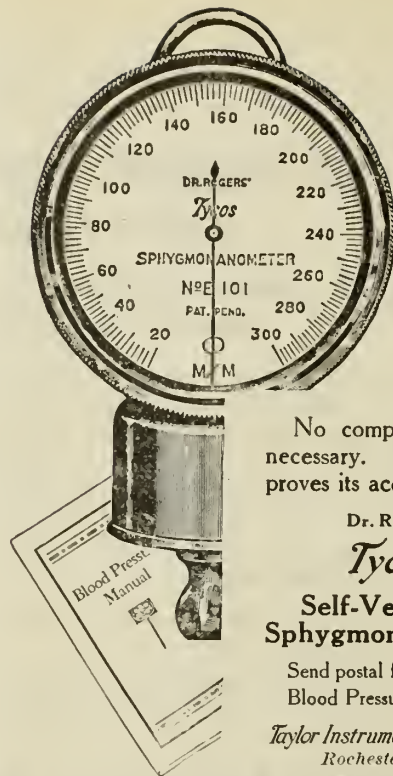
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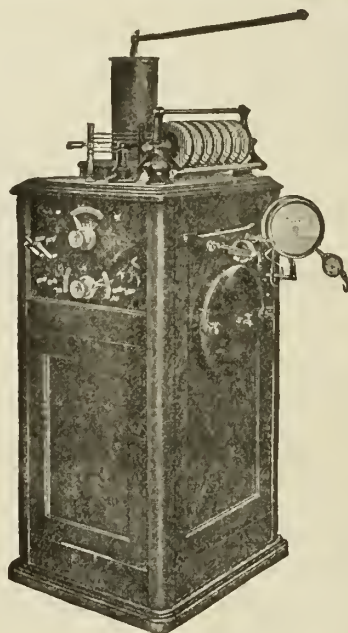
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DECEMBER, 1918.

No. 5

***MAINE'S DEFECTIVE DELINQUENTS AND BACKWARD CHILDREN.**

BY DR. GUY G. FERNALD.

The honor and the opportunity of addressing Maine's physicians on this most important and timely topic suggested by your honored president is deeply appreciated. Maine's children will soon be her citizens and soldiers and the keynote of our presentation may well be the problem of elevating the standard of citizen efficiency for the sociologic betterment of all by the more complete utilization of all available energy.

Doubtless our province should be limited to a statement of some of the psychologic elements of this problem, leaving its solution and the adaptation of adequate methods of attack to your efficient sociologic students and medical experts. Some of the elements in this problem may be stated in a few bald sentences.

Dependency is largely due to mental inadequacy or alienation.

Provision has been made in this State as in most States for the intra-institutional feeble-minded.

The adult feeble-minded habituated to shiftlessness and idleness may not generally be transformed into producers.

The young, however, may be trained to habits of industrial occupation which persist so long as competent supervision is supplied.

The extra-institutional youthful feeble-minded, then, is the group comprising the transformable portion of dependents.

*Read before the 1918 session of the Maine Medical Association.

In our civilization the strong and well will always care for the weak and ill; but, by taking thought, we may justly utilize the unimpaired physical energy of the extra-institutional feeble-minded for the common weal.

The Germans systematically search out the form of maximum usefulness of mental weaklings and keep them occupied thereat under requisite supervision.

Feeble-mindedness is 80% inherited, hence Maine's law providing against the marriage of the feeble-minded is a scientifically wise measure and should be enforced. Numerous instances may be cited of its evasion.

The great majority of our potential criminals, prostitutes, licentious, idlers, shiftlings and vicious generally are now of school age in broken or wretchedly inadequate homes or in eleemosynary institutions which supply homes so far as it is possible to be done by charity.

The reason most extra-institutional feeble-minded are an expensive menace is that the oversight and discipline which is essential is not supplied by the home or by other means.

The expense of caring for the intra-institutional feeble-minded is admittedly less than the cost of their unrestrained activities in the community, therefore the cost of supervising and controlling the activities of the extra-institutional feeble-minded and of teaching them to work would be far less than their maintenance in idleness.

The differentiation of the extra-institutional feeble-minded may be determined authoritatively by physicians especially trained in psychiatry and approximately by physicians who give special attention to nervous and mental diseases.

An adequate system of public school inspection would be a most valuable aid in revealing suspected cases of feeble-mindedness early enough for industrial training to be effective.

All recidivists and almost all first offenders present some of the innumerable combinations of intelligence defects and character deviations of which psychiatrists are quick to appreciate the significance and the importance of differentiating.

Intelligence defects are stationary and irremediable, but character deviations are susceptible of improvement in youth, and from their correction we may expect the elimination of the most inimical of the behavior disorders of the extra-institutional feeble-minded.

For clarity we submit a tentative scheme of mentality study, which provides for the separate categorical treatment of intelligence defects and character deviations.

OUTLINE OF MENTALITY STUDY.*

Mental Integrity.

Mental Disorders.

Mental Functioning in

Mental Health }
Mental Diseases } (manifest in symptoms).

Fields of Inquiry	{	Physical condition.
		Heredity, environment.
		Constitutional disorders:
		Recoverable psychoses.
		Recurrent psychoses.
		Chronic psychoses.
		Chronic psychoses without deterioration.
		Chronic psychoses with deterioration.
		Epilepsy.
		Huntington's chorea.
		Disorders of exogenous origin:
		Traumatic psychoses.
		Alcoholic psychoses.
		Syphilitic psychoses.
		Other groups:
		Senile psychoses.
Arteriosclerotic psychoses (non syphilitic).		
Brain tumor.		
Cretinism and myxoedema.		
Disorders of uncertain nature or etiology.		

Mental Functioning in

Intelligence Integrity }
Intelligence Deficiency } (manifest in decisions).

(In terms of mental level or I. Q.).

Fields of Inquiry	{	Physical condition.
		Heredity, environment.
		Volitions, inhibitions, motives (selective).
		Habits of thought, reason, judgment.
		Memory, general information.
		Association of ideas, initiative (planning).
		Scholastics, religious training.
		Foresightedness, perception.
Apperception, description, imagination, etc.		

*In devising and adapting this tentative working scheme, grateful acknowledgement is accorded Major A. J. Rosanoff, of King's Park Hospital, for his "Classification of Mental Diseases," and Dr. W. E. Fernald, Superintendent and Director of the Psychopathic Clinic of the Massachusetts School for the Feeble-minded, for his "Fields of Inquiry" under Intelligence Deficiency.

Mental Functioning in

Character Rectitude }
Character Deviations } (manifest in behavior).
 (In terms of variety and degree).

Fields of Inquiry	{	Physical condition.
		Heredity, environment.
		Volitions, inhibitions, motives (operative).
		Instincts:
		Habits of action, disposition.
		Temperament, emotionality, sensibility.
		Impulsiveness, initiative (action), honesty.
		Adaptability, fortitude, egotism.
		Altruism, control, patriotism, conscience.
		Loquacity, attention, suggestibility.
		Reactions to opportunity, competition, etc.

In the current popular conception of the term feeble-mindedness consists of analysis of elements of character deviation as well as of elements of intelligence defect. Most intra-institutional cases show very little character deviation but conspicuous intelligence defects, while prisoners generally show grave character deviations, though possessed of sufficient intelligence to succeed socially and economically, if they would control themselves. Character deviations are contralable in the individual, while intelligence defects are not.

That prisoners with character deviations predominating in their mental makeup could control themselves, while the intellectually deficient cannot control themselves, has always been recognized by legal jurisprudence, which holds the offender responsible for his acts, but excuses the poor thinking of the imbecile and the insane. As thinking is the function of intelligence, action is the function of character. The law says a man must act within prescribed limits, but places no restriction on his thinking. "In actual daily usage a man may think whatever he pleases so long as his acts do not contravene established legal or social forms." *

We have many ingenious tests for the elements of intelligence, but there have been but few offered to apply to the elements of character. A means of measuring the character rectitude or deviation of the prospective bank cashier or of candidates for appointment to positions where graft is possible would be a desideratum, indeed, in these days of premium on honesty.

The current popular notion that the poor are indiscriminately to be pitied and helped by giving is one brought along from childhood

*"Character as an Integral Mentality Function." "Mental Hygiene," Vol. 11, No. 111, July, 1918.

through lack of insight and is to be deprecated; if only for its inadequacy. The student of the living conditions of the poor finds that the poor widow of the story book, assumed to be well equipped in intelligence and character, struggling to support herself and children, is the rare exception rather than the typical unit. The poor generally are the improvident, the poor managers and often unable to sacrifice temporary gratification for ultimate benefit.

Those in poverty are	{	Economically poor, but often Sociologically vicious and Psychiatrically deviate or defective or both.
----------------------	---	---

The popular impulse is to give something, but in finding a psychiatric remedy we must treat the disease. Charity deals with economics, science with the underlying vice due to defect or deviation or both. True helpfulness consists in enabling rather than in bestowing.

The shanty and cheap tenement dwellers are poor, to be sure, from the viewpoint of economics, and as such are to be helped as the charitable organizations are doing most nobly, but sociologically the occasion of the poverty and failure is vice and inefficiency, and psychiatrically and psychologically the real cause of the poverty and failure is intellectual defect and characterologic deviation. With these latter, current popular usage and the charitable organizations cannot cope.

The problem of poverty and failure is the problem of dependency, or, in popular parlance, the problem of feeble-mindedness. The charitable organizations have struggled bravely with the problem of dependency, but their efforts have been applied too far from the source, the causes, to be effective.

It is well established that defective intelligence is stationary and irremediable. It is also well established, though less commonly known, that character deviations, while even more potential in the production of dependency, are susceptible of improvement in the formative period of life, but not afterward. If a child's character development be safeguarded, even though there be some degree of intellectual defect, a non-criminal adult results. And, if the safeguarding of character development includes the formation of habits of industrial occupation under the supervision which all defectives need, then the individual is a producer of limited capacity.

We all know of cases of feeble-mindedness which have been sheltered and well trained to habits of usefulness, who have not been dependent nor inimical, and we all know of many cases of the well equipped intellectually whose character development was warped and deviated in the formative period and who were inimical, sociologically and economically, apparently as a consequence. Of course the broken

home occasions very many of these failures and social menaces. When we deal scientifically with those in broken homes many may be salved to social usefulness. The charitable organizations have striven nobly and have held the field for those who can treat the causes and occasions of dependency, when they shall organize and come into the field. The efforts of the charitable and philanthropic are not to be antagonized or adversely criticized, but encouraged and directed. Social workers for charity may be trained to become efficient field workers for character formation of the young. A campaign of teaching, supervising and controlling the rising generation in broken homes should supplant our almsgiving.

What is needed as machinery for the realization of the scientific and philanthropic purposes to uplift our dependents and transform such as are transformable from dependency to usefulness? First, a central, State-made authoritative commission or staff of psychiatrists to effect the registration of all dependents and of applicants for marriage licenses, and second, to direct the activities of a corps of field workers in direct contact with the feeble-minded of their respective districts. If the unfit be prevented from parenthood for a generation and the rising generation be supervised and trained to limited usefulness the diminution of dependency is accomplished. We may not look for the elimination of dependency, since there are other classes of dependents than the mentally ill equipped, but we may diminish dependency for this and succeeding generations by transforming the transformable and preventing the birth of the unfit. Obviously, none but a strong scientific organization backed by the State can cope with this problem effectually.

The time is ripe for administering scientifically the care of our dependents so generously undertaken by charity, but inadequately executed, since charity cannot provide against reproduction of the unfit nor train them effectually for industrial productiveness. It has been amply demonstrated that a training to habits of work, especially at simple occupations in youth, and in character formation in the formative period, results in the salvage to an adult lifetime of limited productivity of the extra-institutional feeble-minded, who, left to their own devices, become dependents, many of them vicious. The intelligence of many an unskilled laborer is that of the feeble-minded and his history that of failure at school, but having been fortunately protected in childhood and early taught habits of work, his character developed favorably later and that and the habit of work prevent his economic failure.

It has been estimated that the prevalence of feeble-mindedness in the United States is from three and one-half to five per one thousand

of the population. If Dr. W. E. Fernald's estimate of four to the one thousand be applicable in Maine, then we have nearly 3,000, of whom 787 are between the ages of five and twenty and consequently amenable to industrial training and correct habit formation. Most of these are of the extra-institutional group. They are now in school as backward children or are idle, as very few of them are at work. The expense to the State maintaining these 787 in a lifetime of idleness and criminality will be very great.

Maine pays annually from the public funds nearly a million and a half for the maintenance of about 12,000 dependents, not including the cost of courts and police, or about \$1,200 each. It would be wise to divert some of the cost of physical maintenance to the utilization of this available energy. Many able-bodied feeble-minded could be made self-supporting under supervision.

This problem which we have attempted to outline is not unique in Maine, but is vexing every community. In many other States organizations of experts and citizens are striving to solve it, especially in this time of need for man power, brain power. An organization of students, legislators, physicians, and of the competent and patriotic generally, would greatly assist in reaching a correct viewpoint and the evolution of the best method of approach to this great question of the diminution of dependency.

New Jersey and Rhode Island are attempting to solve this problem at once in this generation by enforcing a law just passed requiring all the idle to secure employment, but these measures ignore the character deviations and established habits of idleness of most of those it is sought to reach.

Michigan has a law which goes a step beyond the law of this State providing against the marriage of the unfit. The Michigan law provides that as a prerequisite to the issuance of a marriage license applicants shall provide themselves with a medical certificate of mental and physical health. This law seems to be a dead letter, because no provision was made for the remuneration of medical examiners nor for their qualifications to make mental evaluations. The legal principle is valid, however, and could be made effective. The last generation has seen the awakening of scientific thought and altruistic endeavor in this field.

In twenty States there have been formed in very recent years local organizations of citizens, students, physicians and experts to devise measures for the promotion of local mental hygiene, and it is generally the well considered activities of these bodies that are responsible for the effective measures that have been taken for sociologic and eco-

conomic betterment through the conservation of physical and mental energy in the last analysis, the nation's power. The fundamental purpose and methods of these local societies, as of the National Committee for Mental Hygiene, is an enabling of efficiency rather than a bestowal of goods, an improvement of character in the young, enabling an improvement of economic conditions.

By whatever method Maine's citizens decide to act for the conservation of her brain power, much of the best of which has gone to other States in the last few generations, these two facts seem to stand out too prominently to be ignored: (1) the feeble-minded may be and should be prevented from reproduction, and (2) the youthful extra-institutional high grade feeble-minded may be and should be trained and supervised to habits of industrial usefulness for their own uplift as well as for the common weal.

In 1915, Dr. W. E. Fernald, our most eminent authority on the education of the feeble-minded, suggested the registration of all extra-institutional feeble-minded at a central governmental bureau where their activities could be supervised. Dr. J. M. Kenniston, a noted psychiatrist, now a resident of Maine, and others also have advocated registration. Such registration presupposes examination and case study, undoubtedly.

The following case studies are submitted to illustrate the method of study for the purposes of the survey. They do not illustrate the physical squalor and moral degeneracy of the families whence many of our subjects come—so called homes, in which bathing is almost unknown and the number of beds falls far short of the requirements of health and decency in localities where little girls of twelve to fifteen are out on the street from their places of abode till twelve P. M. often. The moral atmosphere in these places is not to be publicly detailed. We do not apologize for these statements nor for the case reports to follow, for we have been conservative and considerate in dealing with the unwelcome and unwholesome. Something of the actual conditions should be known. It is our purpose to awaken your character and inform your intelligence, but not to shock your sensibilities.

CASES.

CASE No. 20.—H. N., aged 24 years, 3 months, born in Nova Scotia. Her father is a fisherman who uses alcoholics to excess, as does her brother. No history of venereal disease known. One of her three sisters died of tuberculosis. Her mother, always frail, died of tuberculosis while H. was small. She attended grammar school and was regularly advanced up to the age of fourteen. Her only reason

for discontinuing was disinclination. Her sex transgressions began as early as twelve. One sister seems to have set her a bad example. One sister is married, and it was with her that she made her home in this State when she eloped from her home in Massachusetts on leaving school at fourteen. Her sex irregularities with men and boys continued while she worked in a mill and led to her living two years in a house of ill fame, where she made \$185.00 in one week for herself. She was with a traveling hurdy-gurdy show for a while, where she did very well financially, though her pay was \$10.00 a week. Two years ago she was married to a French Canadian, who is faithful to her in her present trouble, sentenced for robbery to six months in jail with suspension of sentence on condition that she leave the State in three weeks.

Intelligence: Mental age level, 15 years, I. Q. .90, category, adolescent.

Character rectitude or deviations: Talks loosely of suicide. Volunteers she is pregnant and that she will kill the child if it be born in prison. Is bitter against the organized authorities of justice and takes no attitude of self blame or regret, though she was emotional in speaking of her past. Her appreciation for her husband's loyalty seems very inadequate.

Sociologic maladjustment: Prostitute and criminal tendencies.

Mental disease: None, though she is depressed by her situation and talks in an ill-considered way.

CASE No. 38.—K. J., aged 18 years, 5 months. Father, an Irish African, an immoderate user of alcoholics when K was born, but now said to be an abstainer. Mother, who was once divorced, was feeble-minded and had been an inmate of the State School for Girls. She died suddenly of "shock", it seems, when K. was sixteen. K. is an only child. Her school attendance was very irregular. She gives a history of skipping some grades and of repeating others. Physically, she is in good health and strong, but her personality is unattractive, expression is forbidding and her disposition is intractable. Right eye shows inconstant internal strabismus. Her low and narrow forehead shows deep transverse furrows. When six or seven she was in a convent. When in the State School for Girls, at twelve she was placed on probation, but became sexually intimate with boys. When, however, she became intimate with soldiers she was apprehended and returned.

Intelligence: Mental age level, 13 years, 6 mos., I. Q. .84, category, subnormal.

Character rectitude or deviations: Has very little regard for truth, endeavoring to give a better impression than was true. Temper

is violent and self restraint is very weak. Is egotistic and lacking in filial regard and altruistic impulses. Has no plans for self defence and upbuilding nor ambitions therefor, apparently.

Sociologic maladjustment: Sex immorality; dependent, vagrant tendencies. She has intermittent choreiform muscular twitchings.

Mental diseases: None.

CASE No. 40.—E. W., aged 15 years, 2 months. Father is native born, a fisherman. Her mother, also native born, died when E. was fourteen. School attendance much broken. Her father began sex relations with her when she was six years old and continued it for four years, in fact, while the opportunity lasted. She has been intimate with various boys and men since, and with her uncle, but never for money. Boarded out with her grandmother on the initiative of the selectmen of the town. She ran away several times and on her return home was again abused by her father. Physically, she is undersized and unattractive, her teeth being very irregular and crowded, her mouth asymmetrical, skin rough and right eye showing internal strabismus (crossed).

Intelligence: Mental age level, 9 years, 8 months, I. Q. .66, category, middle grade moron.

Character rectitude or deviations: She shows no interest in her condition or outlook. Her attitude was rather sullen, unaccessible and hopeless. She admitted readily attempting no concealment, but volunteered nothing. She knows very little of the possible consequences of her abuse—had never thought of the possibility of conception. Self respect seemed to be almost wanting. Lack of effort was an outstanding feature.

Sociologic maladjustment: Sex immorality; dependent, abused child.

Mental disease: None; nervous disease: choreiform muscular spasms.

DR. CARL J. HEDIN: Mr. President and Members of the Association: Dr. Fernald has given us an excellent dissertation on questions in which we are all interested. There is no question in my mind that we spend altogether too much money on misdirected charity. Eighty per cent. of feeble mindedness is inherited. Dr. Fernald has said that dependency is largely due to mental inadequacy and character deviation. Now, what are we doing to prevent the continuation of this problem? Let me illustrate by citing two cases. Recently we had applications for the admission of two women at the School for Feeble-minded, each about thirty-five years of age. Each had had ten illegitimate children and each one of those children was said to be mentally defective. One woman, before we had time to accept her, was allowed to go to the State of New Hampshire. The other was allowed to marry. So they were not committed and are at large. We know that those two women left us twenty

dependents. We do not know how many more they will leave us, neither do we know how many more the next generation will bring forth. Now, it is evident that, if we are going to get ahead of this problem, we must strike at the root of the trouble, first, by preventing the reproduction of the unfit, and second, by the proper supervision and training of all mental weakness.

CHAIRMAN COOMBS: Dr. Tyson, of Augusta, has submitted a written discussion of this paper, which our President will read.

DR. TYSON: Having been asked to discuss Dr. Fernald's paper, entitled "Maine's Defective, Delinquent and Backward Children," I feel that a word of appreciation is due Dr. Fernald for the manner in which he has handled this vital problem in the interests of not only the medical profession, but of the citizens of the State of Maine. We should congratulate ourselves and be thankful in our appreciation of his work that the Maine Commission on Provision for the Feeble-minded was able to obtain the services of such a scientific and practical man by assignment from the National Committee for Mental Hygiene.

Dr. Fernald has epitomized briefly, concisely and admirably for us the important facts in his statement, and it is definitely up to us as citizens especially trained to promote the welfare of society in general to formulate methods of action that will constitute a rational and practical procedure in our endeavor to reduce to a minimum the menace of the feeble-minded upon our physical, moral and economic welfare. It is easier to prevent than to cure disease, and, as feeble-mindedness, constitutional inferiority and insanity are such serious calamities, every effort should be made to promote a rational prophylaxis.

Suggestions which are tangible and feasible for a beginning have been made by which practical results can be assured. It has been stated that eighty per cent. of feeble-mindedness is inherited, therefore let us unitedly support in every way possible the enforcement of our recent law against the marriage of feeble-minded, and protest vigorously each instance of its evasion.

We should not wait until very evident cases of feeble-mindedness are brought to us for advice and examination, but should inaugurate systematic methods of examination for feeble-mindedness in all of our public schools. This would enable us to start children in a special course of industrial training that would make the majority of them independently productive and not an economic burden when they reach maturity.

It is not necessary nor desirable that we care for all of our cases of feeble-mindedness in an institution, but our institution for the training of these unfortunates should be of ample size and of sufficient equipment to train all that it may be necessary to send there. It should also be of sufficient size to accommodate the necessary number that demand custodial care because of decided anti-social tendencies.

The present method of detecting cases for training in our own school is unsatisfactory and in many instances unfortunate because of an improper selection. We are greatly indebted to our Governor and Council and the present Board of Trustees for their lively interest and co-operation with the people in endeavoring to improve the present conditions and to provide additional accommodations for a large number urgently in need of custody and training as rapidly as possible.

The suggestion that a centrally located commission or staff of psychiatrists

to examine and classify all cases offers an easily effected solution of the present difficulties. The services of the medical staff of the Augusta State Hospital, for instance, could be utilized in this work and be subject to the direction of such a commission. The preliminary process of examination and classification of all cases would be carried out in a separate department in connection with the proposed psychopathic building to be located on the grounds of the State Hospital as an adjunct to the regular work in mental cases. In this manner properly selected cases would be grouped scientifically for distribution to our own State School or to other properly organized agencies. In addition, the services of properly trained social workers would be available for the necessary field work in following up discharged or paroled cases still in need of supervision.

In conclusion, I wish to emphasize the fact that the problem of the feeble-minded is not entirely hopeless, and I want to encourage the thought among the skeptical that much can be done to minimize the untoward effects of feeble-mindedness in the community if we are not afraid to assume an aggressive initiative by grasping the opportunity to carry into immediate effect the practical suggestions offered.

Dr. Fernald has analyzed the psychiatric problems involved very cleverly by separating intelligence and character and treating these component deviations from the normal, separately and quite independently. We cannot hope to remedy defective intelligence, but we may modify conduct and prevent harmful deviations in character by safeguarding the individual with a suitable environment and the assistance of proper training.

CHAIRMAN COOMBS: The paper is open for general discussion.

PRESIDENT SPALDING: It seems to me, before a general discussion of this paper, that my remarks might come in, and, if there is no objection, I will read a very brief paper in regard to my views of the feeble-minded.

DR. SPALDING: So far as the feeble-minded are concerned, are we not justified in studying every one of them from the viewpoint of inherited syphilis? I would next ask if much might not be done to improve such children by paying particular attention to accurate testing of the sight and hearing of each and all of them? I do not refer to offhand examinations of the sight, merely, but I would have a painstaking examination of each eye separately for the sight, field of vision for white and colored objects, perception of colors generally, and whether or not the two eyes balance perfectly under all possible conditions, so that there is positively no suspicion of latent double vision. The size of the pupils and variations to light should be tested. So, too, with the ears. I would have them examined and tested for perception of the voice, tuning forks and watch, and the musical perception of tones over a wide range like the scale of a piano.

The influence of music seems to me to be worth studying for the care and improvement of the feeble-minded. By this I mean playing and singing to them. Furthermore, would not musical instruction be valuable for some of them? Some children hear better by the air, and others by the teeth and bones of the head. Could not, now, the air-hearing children be taught music by singing lessons and piano or violin instruction, whilst those hearing better by bone conduction could utilize instruments that touched their lips or teeth, such as

fifes, flutes, clarinets or even the Jew's-harp? Sounds thus brought nearer the brain might act more beneficially. It is worth suggesting, I believe.

Could ordinary instruction in reading words and in arithmetic be obtained better for the feeble-minded by the ear than by the eye? In other words, do we differentiate enough in instruction between the influence of images and sounds? I ask next, though it may have been asked before, is especial care taken in all feeble-minded children to study the defects in curvature, if any, of the spinal column? I believe that in all these cases we must carefully study each child from the viewpoint of as perfect a body as possible. Finally, would it not be advisable to test in all of these defectives the blood serum and the cerebrospinal fluid just as conscientiously as the eye specialist advises the patient with retinitis to have a urinalysis.

DR. NORTON, of Lewiston: Mr. Chairman, I want to emphasize what Dr. Spalding has said in regard to the study of the physical organization in those who are defective. I cannot give you any statistics in regard to the hearing and vision of defectives. I can only say that in my small experience, having examined a few of them, I have found in every case that I remember of at present, serious optical errors, or, rather, optical and muscular. I have found in many cases almost complete deafness. Many teachers will tell you that a pupil was regarded as simple-minded, or partially so, but that when the pupil had a proper fitting of glasses, the mental condition improved with great rapidity. Many children, I believe, are regarded as partly mentally deficient, when the trouble is largely, if not entirely, physical. Now, I do not undertake to say anything about the psychic problem, but I do believe that one of the first things to be done in the case of a child that is apparently mentally and physically defective is to give him a complete and thorough examination of his physical organization.

CHAIRMAN COOMBS: I wish to add my own observation of twenty-seven years in one locality, that all the mental defectives who have been living in that locality during that time come from two families. Is there any further discussion?

DR. BRYANT, of Bangor: I would like to ask why it is practically impossible at the present time to get a child of the proper age into the Home for Feeble-minded. I have tried several times in the last three or four years, with children who would be of the age to be well trained and who could be made to a certain extent, useful citizens and partially self-supporting, to get them into the School for the Feeble-minded, but there is so much red tape, and the objections raised are so strong, that it is practically impossible at the present time to get a child of the proper age into that school. I would like to know the reason.

DR. HEDIN: The reason is simply this: We have 180 on the waiting list and the school is crowded to the utmost limit. The Trustees give preference in accepting cases to girls of the childbirth period, from 15 to 45, who are apt to have children and propagate their kind, and they give preference next to boys who are vicious. We accommodate 282 and have a waiting list of over 180. Very few are able to go home and support themselves. We have to accept from the different counties in proportion to the population, and we are trying to give each county in the State the same chance. That is the reason why the people have to wait.

DR. BRYANT: Could not some of these older ones be weeded out into some other home, where there is practically no hope for them?

DR. HEDIN: I think some of them ought to be returned to the towns from which they came.

DR. BRYANT: Should not these younger children, where there is some hope of training them, be given the preference instead of keeping a practical poor farm for these older people?

DR. HEDIN: I think so, but when you try to get them home the politicians all over the state oppose it, and there you are. Does that answer the question?

DR. BRYANT: What would be the solution?

DR. HEDIN: Of course we now have a law between 6 and 40. After 40 the Trustees, of course, have the right to discharge them if they are harmless; in fact, the Trustees have the authority to discharge harmless cases now. The point, however, is this: As a matter of fact, when the school started they dumped into it all the criminals and worthless cases—idiots—that we can do nothing for except to keep them in custody and give them care. To be sure, they need a home and proper care, but they are taking the place that these younger cases should have for treatment. I have done all I could to change that. You understand, the pressure from the people is great to keep the most helpless there, and when we try to return a helpless case, or one that cannot take care of himself, the whole community rises against it, and sends its selectmen and other prominent representatives to oppose it. The only way it could be done would be to have a law passed that harmless cases should be discharged.

DR. BRYANT: Or else have some institution to which these could be referred, and not take the chance of a child who could be practically trained up to usefulness. It is practically a home for cripples and the unfit.

DR. HEDIN: Yes, it is now a home for helpless cases.

CHAIRMAN COOMBS: If there is no further discussion, will Dr. Fernald close the discussion?

DR. FERNALD: Mr. Chairman, Ladies and Gentlemen: I only wish to add the observation that the discussion discloses the acute interest which is taken in this problem, and shows clearly the need of study of Maine's problems regarding the feeble-minded. Every state in the Union is keenly alive to the need of doing something. One state makes an attempt in one direction, another in another. There is no uniform process; there is no best method for all communities that has been devised, and Maine people must find the best way of taking care of Maine's defective children. As generation has succeeded generation, as more and more of the best blood of the State has left it to help in the formation of other communities in the West and South, the breeding stock has left some strains which are breeding true to it, and are leaving us with a pretty large percentage, I fear, of feeble-minded to look after, and it is time that the sociologic students and public spirited students of all kinds should focus their attention on the demands of this problem. All that is needed is study and organization and the bringing together of the ideas of Maine people on Maine's problem. Something more ought to be done than can be done by any one man working a year in the State and making a little beginning. The work which

I have been able to accomplish is pretty small, of course, but even that will be lost unless the slight impetus is given a further impetus by Maine people, and particularly by this organization. I hope that this attempt will not be allowed to be the end of all that is done in the interest of better methods and better doing for the feeble-minded. Some action possibly might be considered by you with reference to the further consideration of this question by a committee, or the instruction that some member prepare a paper for the next meeting to show what has been done during the year, and what should be done, on this question—some advice providing against the cessation of all effort in this direction, because the question is too big and too imminent to be allowed to wholly lapse. I simply leave this as a suggestion for you. I thank you. (Applause.)

Necrology.

WILLIAM SEWARD THOMPSON

Standish.

Dr. Thompson, a very active country practitioner, long settled in Standish and well known in that part of Cumberland County, died very suddenly on the evening of Tuesday, October 1, 1918. Dr. Thompson was a well-educated man and a reliable country physician. Good schools, good clean politics, good water and good public health were the points which he inculcated everywhere in the community. As a practitioner of medicine his pleasant manners went a great way, where medicines do not always reach.

His career may be summed up in this way: He was born in Kennebunk, October 14, 1854, the son of Melville and Caroline Stevens Thompson, and educated in the schools of Biddeford until he was fitted for college. He then chose Dartmouth for his academic degree, which he obtained with honor in 1879. He attended lectures there and obtained his degree in 1882. He took for the topic of his graduating thesis, "Dietetics," for which he always after argued as part of successful medical practice. He then settled in Standish and carried out his life to a perfect ending, dying without real warning or lingering illness. He married Miss Imogene Edgcomb, of Hiram, who died in 1903. He married late in the following year Miss Mary Janet Rand, of Standish, who, with two children, a promising son and a daughter, survives him.

J. A. S.

ANDREW ALLEN BROWN

Bangor.

A former city physician of Bangor, and at the time of his death, April 25, 1918, superintending physician of a tuberculosis sanatorium at Avondale, Arizona; Dr. Brown was born in Mt. Desert, Me., March 17, 1876, the son of Amos Sheldon and Leonice Leighton Brown. After studying in the schools at Southwest Harbor and at Bucksport Seminary, he attended a full series of medical lectures at the Bowdoin Medical School and obtained his degree in 1901. He studied obstetrics in the New York Lying-in Hospital and devoted considerable time to general medicine and surgery at the City Hospital in Boston. Soon after completing his post graduate studies he practiced in Monson, Me. In 1912 he moved to Bangor, where he served as city physician. He became afflicted with rheumatoid arthritis and suggestive symptoms of tuberculosis, so that he removed to Arizona, where he soon improved greatly and settled down to work again with a hospital service. He fell ill with pneumonia and died in the early spring of the present year. His body was brought to Bangor for burial.

Dr. Brown married early in life Miss Gertrude Gilbert, of Bangor, daughter of Frederick and Caroline Howard Gilbert, who, with a son, survives.

J. A. S.

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*Editorial Comment.***DR. FERNALD'S PAPER.**

A glance at the trend of current professional opinion and activity shows the remarkable hold the sociologic aspects of medicine are taking in both professional and lay thinking. The wholly altruistic and philanthropic organizations and propaganda of the many State Societies for Mental Hygiene, and the National Committee for Mental Hygiene, with its immensely conserving war work branch, and the just announced organization of a course in psychiatric social work to be offered this summer at Smith College to graduates of women's colleges are examples. Dr. Myles Standish, an honored Bowdoin alumnus, who is to deliver the annual discourse at the mid-June meeting of the Massachusetts Medical Society, has chosen as his subject "The Socialization of the Practice of Medicine."

As in mental development the altruistic mental functions are reserved for the period of adult mental life, we may expect these later developmental days of the profession to be characterized by the altruistic trend in the minds of the leading medical men of the generation. Medical men everywhere may well take pride in the fact that their confreres have conceived, organized and are operating the medico-social movements indicated above, as well as others.

VENEREAL DISEASE CONTROL—BOARD OF HEALTH BULLETIN, SEPTEMBER, 1918.

We have received from the State Board of Health its September Bulletin on the above topic. It is one of the most important yet issued from this invaluable department of State medicine, and every physician will give it careful reading and keep it always ready at hand for proper legal notification of all diseases coming under this title. It is high time that cases of this sort were declared dangerous to the public health and to be reported. The rules given in the Bulletin are plain and well written, and, disagreeable as it may be to some physicians, each and every one of us must do his duty under the law as a future protection to others, even ultimately perhaps in his own family, if he has children growing up around him. The JOURNAL commends the present Bulletin unreservedly, and expects every physician to keep posted concerning the enlightened work of our able State Board of Health as it daily continues its usefulness in the one great item in public health, prevention of the extension of diseases of every sort.

Especial emphasis should be laid by physicians on Section 2 under Rule 4 of the proper notification of parents or guardians of minors afflicted with the venereal.

Rule 6 is likewise noteworthy, in that it prohibits druggists from the secret treatment of the venereal by unknown remedies, and it might have been of value against deceit to amend the directions so as to include men who might try to shield themselves under their trade label of "Apothecary," claiming not to be druggists.

THE INFLUENZA EPIDEMIC.

We have received a belated letter from the Council of National Defense to Members of State Executive Committees, County Representatives and to the Volunteer Medical Service Corps, calling attention to the need of instructing families to guard against the epidemic by cleanliness about the houses, avoiding the stirring up of dust, persistence in washing with soap and water about the rooms, gargling and spraying the throat and nasopharynx. They are also urged to co-operate with local and State Boards of Health, urge the importance of fresh air and avoidance of chills and overheating personally or of the houses in which they live, and especially to be careful in treatment to give no medicines likely to decrease the vital forces of the patient, particularly the heart.

They are asked to use their own materials for medical and surgical supplies, to take nothing from the Army or Navy, make their own masks and dressings, and not to operate at all unless the operation is necessary to save life.

Although belated, these suggestions still have their value for sporadic cases of the influenza, and the JOURNAL is glad to assist in the good work by printing the request of those in authority in abbreviated form as better late than never.

MALINGERING IN THE FRENCH ARMY.

This disagreeable occurrence in the face of the enemy has been occasionally observed amongst the rank and file of the French army in the following typical instances; picric jaundice, artificial abscess and erysipelas.

If a small amount of picric acid is wrapped in cigarette paper or in a crumb of bread and swallowed with a drink of water following, we discover a greenish yellow color of the skin and mucosæ, reddish urine and fugitive malaise. With larger doses the skin color is more defined, the volume of urine decreased, diarrhœa, heaviness in the epigastrium, a tender liver and slackening of the pulse. The only way to distinguish from true jaundice is by absence of the furred tongue, of true epigastric pain, of fever, of clayey stools and itching of the skin. Urinary tests are of no value except in the absence of bile pigments or urobiline, when fraud can be suspected.

Abscesses on the inside of the thigh, almost invariably, and due to the injection of turpentine, paraffin or petrol, must excite suspicion on the part of the surgeon. They are small, painful, the smell when opened, if due to paraffin, etc., is striking, whilst the contents do not show homogeneous pus but a magma of necrotic shreds.

Malingering erysipelas is due to rubbing the skin with thrapsia, and often is observed to occur just before an offensive attack against the enemy has been ordered.

These rare instances of malingering, so far observed, have generally been shown to be due to unscrupulous camp followers in need of money, and who will, for a small fee, instruct soldiers how to bring about the results above mentioned. In one instance a mother gave her son picric acid, with directions how to use, in order to save him from danger of battle.

OUR POSSIBLE WAR PENSIONS.

Careful study of the work begun by the British Ministry of Pensions, as completed and issued up to the date of September 1, 1918, gives us some suggestions concerning the state of affairs with which

our government will be confronted when the war is definitely ended. The grand total already given pensions includes up to that date some 60,000 officers and men, whilst the number discharged from service up to the same date is over 400,000, showing that a very large number apparently entitled to a pension are not, at present, making any claims on the government. Of the entire list of the four hundred thousand, 23% were discharged for wounds and injuries, the remainder for acute diseases and ordinary illnesses more or less amenable to treatment or to the effects of time.

The largest percentage of cases already pensioned was for wounds and injuries of the legs not necessitating amputations, with a smaller list for arm injuries not necessitating amputations. Sixteen thousand amputations so far performed on both arms and legs, and eighty-seven thousand wounds of extremities not needing amputations, is an encouraging aspect of modern conservative surgery.

In the lists so far submitted for publication we note some 20,000 instances of apparently permanent shell-shock, 11,000 of injuries to the eye or eyes, 4,000 to the ears producing deafness, and about the same number of cases collected under the general head of epileptics and nervous affections. Time will probably bring to notice the precise number of the eye-wounded who are blind in both eyes, as well as of the deaf who have lost their function in both ears. It is a far cry from one eye or one ear injured to complete blindness or complete deafness.

Public Health.

HEALTH OF WAR WORKERS.

The Public Health Service Bureau announces that all inspections of war workers, including factories and their sanitation, has been delegated to its care, and a special service directed and already organized. This division will have district offices and will need specialists of the following nature: Industrial physicians, hygienists and sanitarians; mechanical engineers for safety and for production; engineers for illuminating and ventilating, and chemists, some experienced in production of chemicals and others of explosives. The above men should have a good education and some experience, practically. The work is of the emergency character, and it is said that 120 experts are now demanded. This opening should make places for physicians fresh from the schools, and it is very probable that with such a beginning

the government would continue the work after the war and thus give life occupation to those entering at this present time.

We may also add that some present day physicians, not fitted for war service, or already enrolled in the Volunteer Medical Service, might here find an opening, even for temporary service, and of value to the nation.

BETTER SCHOOL BUILDINGS DUE TO THE WAR.

The War Department has decided to establish schools for teaching the children of munition workers living at a distance from the regular city, town or village schools, an idea which has many advantages from an educational point of view. But farther than that, this new department has decided to build schools that are schools, as we may elucidate in this way. For many years our public schools have been danger traps, in that they were built with more than one story. This was, of course, necessitated in cities, owing to the high cost of land, either purchased or rented. But it continued in the country, where land was cheap in every respect. Many of our best physicians skilled in children's education, mentally as well as physically, have long recognized that all schools should be of one story in height only. They argued that it was safer from fire, and that the light and ventilation would be superior to buildings raised into two or more stories. They have, however, always been nagged down by public clamor for lofty schools and cheaper cost of land.

At last, however, the government in this plan for education of children of munition workers has come to the front with a school of a sectional type, each one of one floor, with a direct exit out-of-doors as well as on the play corridor. The smallest schools are of four rooms, with two toilets and a recreation corridor, but these can be easily and quickly expanded into a school building with twenty-four rooms and four toilets. By building such schoolhouses as this, the parents will be enabled to understand their advantages in times of peace, and we hope that people, especially the women, will take the trouble to visit such schools and study their construction, and gradually introduce them in times of peace into our public communities, wherever land can be obtained at reasonable prices.

Medical Notes.

PNEUMONIA AND ITS TREATMENT.

In a letter to the *Boston Medical and Surgical Journal*, Dr. Beverly Robinson writes that the treatment of this disease should be begun early in an isolated, well-ventilated room in a house or hospital, with liquid nourishment and no injudicious interference to find out how far the disease has progressed. Quiet and peace of mind must be promoted by no interference. Inhalations of tincture benzoin compound, with beechwood creosote, a little brandy, whiskey or coffee from time to time, and a tablet of strophanthus tincture (one minim in each tablet) placed beneath the tongue every two hours is all that is needed. A little cascara may be of use occasionally. The writer has no faith in digitalis or strychnia, but believes, with emphasis, that judicious and timely venesection may be of the greatest value. Anything experimental is problematical in so serious a disease.

ARREST FOLLOWING FAILURE TO REPORT VENEREAL.

Des Moines, Iowa, has the first instance of prosecution and conviction of a physician for failing to report a case of this sort. The neglect was discovered and publicly prosecuted by the health officer in the new National Division of Venereal Diseases. One million dollars has been allotted by Congress to be divided pro rata amongst the States to combat the spread of the venereal. All States are compelled in accepting this money to require the reporting of all cases of this scourge to the local health authorities. If such have not been appointed, then the State Boards of Health must join in the work. Iowa, the first State to report conviction for neglect, has received some \$25,000 for its share, and this instance foreshadows the prosecution throughout the nation of all medical men who fail to report their cases.

WOMEN PHYSICIANS.

The Italian women physicians are doing wonderful work in the war zone in Italy in these pressing times. Two of them were caught in Venice in the autumnal retreat of the Italian army last year, and have accomplished a great deal of useful work, especially with the children of that city. They have also performed many operations and cared medically for wounded soldiers. Their names may be enrolled on a national list of women who have made good in war, Corvini, of Cheti, and Fambri and Paoli, of Venice.

MALINGERING.

David of the Bible, before he was king, was afraid of the king of Gath, and in order to obtain a respite he became a malingerer, scrabbling on the gates of the city wall, letting his spittle dribble down his beard, and in this plan he was a success and so escaped. Ulysses, in order to avoid conscription for Troy, busily plowed the sands of the beach and manured them with sea salt, and thus successfully malingered as insane. Sir Walter Raleigh feigned sickness, madness and diseases in order to put off his trial and get more chances for escape.

So, too, in the latest eras we read of a case like this. In New Jersey a boy sued for malpractice, claiming that his injured legs had been so badly treated that he was lame for life. The case went dead against the physician and heavy damages were assessed. Whilst an appeal was going through the Law Court the boy was watched and photographs taken on the sly. In one he was seen being lifted on to a railroad train for a distant vacation, assisted by two men and his crutches. In the next he was shown at the end of his journey jumping off of the same train alone without a crutch. So, too, he was shown before the jury at the second trial as playing a first-rate game at short stop without a cane or a crutch. Short work was made of his malingering.

The end result, if applied to many an instance in Maine, would show the cruel wrongs inflicted upon physicians by verdicts in such cases.

In another instance a sailor sued for \$3,000 damages, and finally got them. Up to the day that the cash was paid over to his attorney he walked with the aid of crutches.



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(2018)

From that day on he walked alone and unaided with any contrivances. A business man feigned sprain of the wrist and incapacity because he could not sign a check. Nevertheless he attended to his business, but stuck out on the disability for over a year, and finally settled on a basis of three weeks' incapacity.

Cases of this sort will occur after the war, and physicians will have to be, as always, on their guard against malingering, or pretending to be much sicker and a great deal more damaged and incapacitated than they really are.

CURIOUS CASE OF DIFFICULT LABOR DUE TO DISTENDED VAGINA.

A primipara could not be delivered owing to the immense size of the foetal abdomen. After use of very powerful traction delivery was effected. The mother made a good recovery. The specimen was found to contain a very enormously dilated double vagina, a bicornated uterus, and an exceedingly large rectum and bladder. The distension was additionally increased by the presence of a large amount of fluid of a clear amber color.

VOLUNTEER MEDICAL NOTE.

We print at once the following letter from our worthy President, confident that it is a move in the right direction for the proper care of the people in rural Maine during the possibilities of the fast approaching winter season. We all know that Maine roads in winter are hard to travel, and any plan which can help the people and give attending physicians the best chance to care for them has our immediate praise.

Nov. 18, 1918.

To DR. FRANKLIN MARTIN,

Advisory Commission, Council of National Defense.

Subject: INADEQUATE MEDICAL SUPPLY FOR RURAL MAINE.

Dear Dr. Martin:—

The recent epidemic emphasized the extent to which the mobilizing of doctors for military service had depleted the rural portions of the State of its needful supply, which, as in other states, was further affected by the deaths among the doctors from epidemic causes.

In advance of opportunity to take this up with Governor Milliken I am writing you, in order that it may be taken up at the Washington end through the various organizations necessary to get results before

these communities are blocked with snow. There are many communities which are sadly in need of a resident medical man.

Talks with traveling men who had visited the doctors during the course of the war convince me that not a small number of men going into the service had in mind that when through with military service it was their purpose to settle in larger places than they had left.

Here is a field for the Volunteer Medical Corps or for the Public Health Service. One man who helped out in the epidemic in the northern part of the State tells me he would be willing to continue under the same conditions as to salary and expenses as provided by the Public Health Service in the emergency, but not to go into one of these towns as a permanent resident.

If machinery could be put in motion to at once release all the doctors in camp in this country who intended to return to their homes and resume work, leaving the demobilization work to those whose homes are in cities, it would go very far toward relieving the situation in this State, but even then there will be a good many towns isolated by weather conditions, who will be very, very much in need of medical aid to avoid calamity.

As soon as Governor Milliken returns to Augusta it is my intention to take it up with him. There does not seem to be any one person whose duty is plainly outlined to take this up, and so I am venturing to do so, hoping that I may stir up matters ahead of weather embargoes and perhaps avert an acute situation later on.

I am, very truly yours,

GEORGE H. COOMBS,

President Maine Medical Association.



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Wheat flakes and oat flakes are combined to yield a most delightful flavor.

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(1941)

WAR NOTE.

CANCELLATION OF THE APPEAL FOR PLATINUM.

The chief of the Platinum Section and of the Section of Medical Industry of the nation made some time since an urgent appeal to the physicians and dentists of the country for scrap platinum for ammunition purposes. The response by both professions was instantaneous and hearty in the extreme. War having now ceased, apparently, the chief of the Platinum Section and of the Section of Medical Industry now takes this opportunity to thank, officially and personally, all physicians and dentists who came to the assistance of the nation in its need for this precious metal, and to inform them that no more will be needed.

Personal News and Notes.

We are congratulating Capt. H. C. Milliken, of Portland, upon his promotion to rank of Major and on being promoted to take charge of a large base hospital on the front.

Lieut. Thomas A. Foster, M. C., of Portland, reports to us under date of November 4th that he is well and busy, over there, and that Lieut. Col. Burrage and Capt. Milliken, also of Portland and well-known members of our Association, are in perfect health and all doing their work for the nation.

A WAR JOURNAL.

We have received from some kind hands unknown to us a copy of *The Camp Sherman News*, printed in Chillicothe, Ohio, November 12, 1918, by the *Columbus Evening Despatch* as a special issue for the camp mentioned. In its columns we note frequent mention of two of our members from Maine, Major Powell, of Saco, and Major Leslie, from Andover, which gives us proof that the Maine Medical Association is worthily represented at Camp Sherman. The newspaper is eight pages in full, and contains paragraphs, editorials, telegrams

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and news of every possible description and especially of the sort that our soldiers would prefer. We note, for instance, space given to Thanksgiving dinner; public appearance of soldiers in uniform, neatness being imperative; the War Work Campaign by the soldiers to help out the soldiers over there; examinations in psychiatry; winter clothing for soldiers; women's work for the boys; letters from soldiers in camp. Much space is given to the work of the Y. M. C. A. and that of the K. of C. Sport has a whole page to itself in its various lines, and the Community House. In a word, the special issue is a very good pattern for a soldier's newspaper and must give great pleasure to all within the limits of the camp. Anybody looking for information as to how our boys spend their time in camp, and what they think most of and are interested in, will find it in abundance in *The Camp Sherman News*. Finally, let us not forget the kindness of those who sent us the paper and gave us the chance to bespeak for it a pleasant word of thanks and satisfaction.

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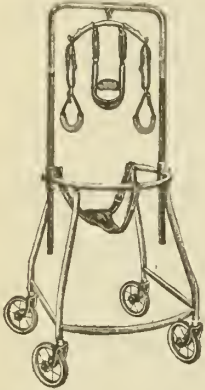
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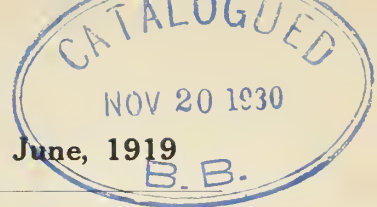
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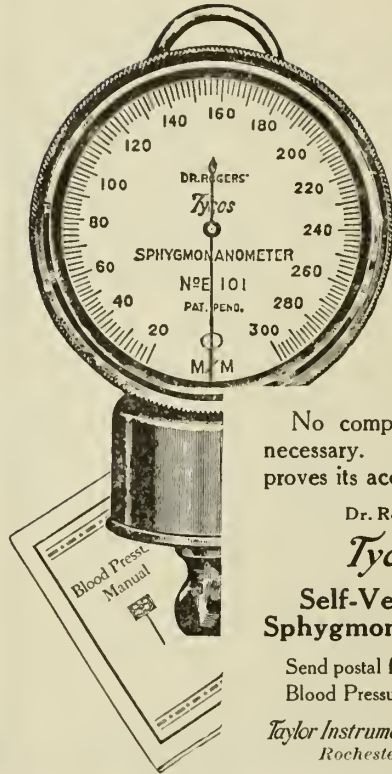
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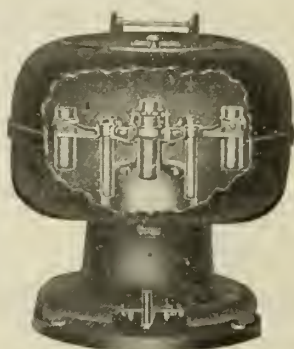
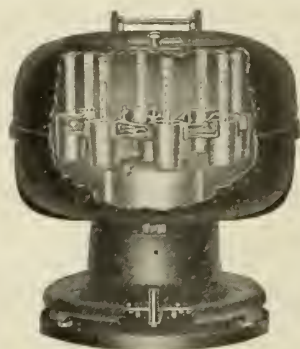
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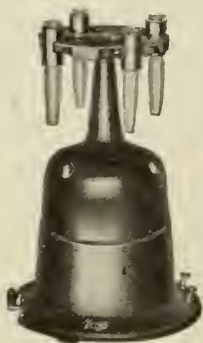
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A CONSIDERATION OF THE TREATMENT OF PEPTIC ULCER—REPORT OF FIFTY CASES.

By RICHARD F. CHASE, M. D., Portland, Maine.

I believe the profession is as perplexed to-day as at any time during the past twenty-five years regarding the proper treatment of peptic ulcer. Some of the causes for this perplexity seem to be (1) the introduction of new medical methods of treatment; (2) the partial or complete abandonment of some of the older methods, and (3) the position surgery occupies in this relation. At the present time no particular method of treatment is used by any considerable number of physicians. As a rule, each man employs a method of his own. This fact alone is evidence that there is no particular method which is entirely satisfactory. Of the older methods, the treatment by liquid diet, bismuth, antacids, etc., with or without rest, has been justly abandoned by good therapists. To be sure, this treatment often gives relief for a time (such results are obtained by most any or no treatment at all), but the symptoms nearly always recur sooner or later, because a cure is not effected. The old Leube method (rectal feeding), still employed by some, seems to be falling into disfavor, mainly because it does not supply the patient with one-third of the amount of nourishment the body requires, even though at rest. Besides, the failures from this treatment have been many. The Lenhartz treatment, introduced in 1904, met with early favor, for the reasons that it is easily carried out and it provides the patient with sufficient nourishment. It is probably the most popular method employed at the present time. Personally I

never favored this method, because I do not believe it provides the amount of rest for the stomach that is *essential* to permanent cures. Many failures have also resulted from this treatment. Unfortunately there is no agreement as to what constitutes a cure in ulcer. As Lockwood says: "The length of time of freedom from symptoms which must elapse after treatment before the patient can be declared cured is an arbitrary one, but it may be said that two years, at least, must elapse before any conclusions can be drawn." On this basis Lockwood, Sears of Boston, Strauss of Berlin, and others estimate that but 50% of cures are obtained by medical treatments in general and in experienced hands. The number of cures obtained by the average physician is probably much less than 50%. Herein is the reason why the profession as a whole has become somewhat skeptical of medical treatments in ulcer.

Surgery has won and occupies a very high position in the treatment of ulcer. It gained its popularity through truly surgical conditions (pyloric stenosis), etc.; it then reached out and embraced, more or less justly, all classes of ulcer. The conquest was an easy one, because we physicians were meeting a considerable number of failures. But even now, under present conditions, it is quite generally *verbally* agreed by both physicians and surgeons that all uncomplicated cases of ulcer should receive medical treatment, and that all cases complicated by perforation, stenosis, etc., should be treated surgically. Yet what is the practice? You know as well as I that surgeons operate on all ulcer cases that come into their hands, provided there are no contraindications to an operation. Physicians, on the other hand, often treat medically (although usually through ignorance of existing complications) cases which are amenable to surgical treatment only. This is a rather lamentable state of affairs, resulting either from unscrupulousness or inexperience. In the future the unscrupulous may be reformed, but certainly at the present time there is no excuse for continued ignorance in this matter. It should be plainly evident to all that in a suspected case of ulcer the first step is to prove or disprove its existence, not by a surgical exploration, if avoidable, but by the use of our medical means of diagnosis, including the X-rays, if needed. (Who has any conception of the number of cases surgically explored for ulcer and no ulcer found?) Next, if ulcer is found, it is equally important to determine, and by the same means as employed in diagnosis, whether the indications are for medical or surgical treatment. These determinations are not always possible in every case, by these means, but nearly always they can be made, and if the physician or surgeon in charge of a case is not equipped to make such determinations then *it is*

his duty to all concerned to refer the case to someone who is so equipped. In ulcer cases, in particular, there is need of honest and intelligent coöperation between the physician and surgeon and the internist. Rarely is a surgeon competent to act wisely in all three capacities. In fact, it has more than once been suggested that the internist should serve as a sort of "clearing-house" for these cases in particular.

To show, in a measure, how such a procedure operates and at the same time to impart whatever information may be conveyed, I will briefly report fifty private cases of ulcer observed in the past three years. Of forty-eight patients, twenty-five were referred by the profession, and two were physicians. The fact that in thirty-one of these cases no diagnosis of ulcer had been made, leads me to believe that there are many similar cases yet escaping recognition. In fact, I doubt if there is a general practitioner present who has not during the past year overlooked at least one case of chronic peptic ulcer. Thirty-seven patients were males, eleven were females. The average age was 47 years. The youngest patient was a boy of 14 years, who had had symptoms for 7 years; the oldest patient was 77 years. The average duration of the disease exceeded 11 years. In five patients the disease had been present from 30 to 40 years. In but four cases was the disease of less than 3 years' duration. In eight cases pyloric stenosis was found, and gastroenterostomy was performed in seven; one case was probably malignant and nothing done. All patients survived the operations and the seven benign cases are generally well from 3 to 30 months since operated. Four other patients were operated upon, three having gastroenterostomies and one an exploration. All died within twelve days of the operations. Thus of twelve cases operated (ten gastroenterostomies and two explorations) by nine different surgeons, four patients died, giving an immediate mortality, directly or indirectly attributable to the operations, of $33\frac{1}{3}\%$. By adding two later successful gastroenterostomies (not included in the fifty cases) we reduce the surgical mortality to four out of 14 cases, or to 28%, which is quite high enough. The surgical mortality from gastroenterostomies by our best surgeons is considered to be about 5%, and this is the figure usually quoted in this relation. In considering this question it is quite important, also, to bear in mind the percentage of the average surgeon. Two other patients were explored and cancer found on ulcer. Both died from the disease. Three other patients, two with stenosis, declined operations. Two are dead and one is living. A patient of 71 years had stenosis, due to cancer or ulcer, but his age and poor physical condition contraindicated operation. The autopsy disclosed cancer, probably on an old ulcer. Another patient was a 2-year post-

gastroenterostomy case, a semi-invalid. One patient had a recurrence of symptoms 19 months after duodenal feeding. I advised operation to clear up the question of an appendix and for ulcer, if indicated. The report was, no ulcer found, some pyloric stenosis, an appendectomy done. Of the fifty cases (two medical cases becoming surgical), nineteen, or practically 40%, were considered surgical and sixteen were operated. In fifteen operated cases and in one autopsy the correctness of the diagnosis was confirmed, in one operated case the diagnosis was found to be incorrect; thus the percentage of diagnostic error was one in seventeen, or 6%. Of the remaining thirty cases, sixteen were treated by duodenal feeding and will be considered later. Of the fourteen cases left, four were treated by other men, three are uncured, four patients have postponed treatment and six have declined treatment. Please take note, of fifty cases, nineteen, or 40%, were not recognized until the disease had existed on an average of over 17 years, when conditions had arisen which absolutely demanded surgical treatment, if anything at all was to be done! Even in the other thirty-one cases the disease had existed on an average of 10 years, and in most cases the ulcer had become distinctly chronic.

Was it not about time these patients should reach a clearing-house? And why is this class of patients permitted to continue years and years untreated? Principally because the general physician fails to recognize the condition. Another reason, offered by the general physician, is that it is often difficult to induce these patients to seek proper treatment. If these patients are convinced, thoroughly convinced, that they have ulcer, and the danger pointed out to them, of perforation, of hemorrhage, of their great liability to cancer, and to eventual surgery (with its not inconsiderable mortality) if their case is neglected too long, then I believe there should be no great difficulty in inducing these patients to seek treatment. A chief trouble is that neither the patient *nor the physician* fully realizes the great seriousness of peptic ulcer. It is well recognized that acute or fresh ulcer yields the highest per cent. of cures to medical treatment, and if all ulcers were properly treated in this stage there would be little need for the intervention of surgery. Do you realize that it is almost always the *neglected* case of ulcer that calls for surgery?

Diagnosis: In all but two cases the diagnosis was based on objective findings in conjunction with the histories. In one case the diagnosis was made on the history alone and in one case on the X-ray findings. The stomach tube was employed in all but one case. Blood from the stomach, or in the stools, as shown by the occult blood test, or by the "thread test," was found in thirty-two cases, or in 64%.

(Formerly blood was encountered in about 40% of ulcer cases.) Pyloric stenosis was found in fifteen cases, in eight of which no blood was noted. Thus blood in thirty-two cases and stenosis in eight cases without blood, were the chief diagnostic symptoms in forty cases, or in 80% of the fifty cases. In the other 20% hypersecretion, with or without hyperacidity, was the principal objective finding.

At this point I wish to speak of the "thread test," devised by Einhorn, a most valuable diagnostic measure. Not only does a blood stain on the thread indicate ulcer, but by showing its distance from the teeth one is enabled to quite accurately locate the ulcer. I now use this test during treatment to determine whether or not the ulcer is healed. In an occasional case by this test I have found the ulcer unhealed although all symptoms had ceased; a recurrence of symptoms confirmed the result of the test. During or after treatment, a negative thread test, with complete absence of symptoms, is good evidence that the ulcer has healed.

In this series of cases I have included several cases of cancer, probably formed on old ulcer, and causing pyloric stenosis. In an occasional case, even at the operation, it was impossible to differentiate between ulcer and cancer, microscopically. Since either benign or malignant stenosis is a surgical condition, a diagnosis of stenosis is sufficiently accurate prior to operation.

To those who have followed many ulcer cases to the operating table it is apparent that some cases (those with organic stenosis and those with large indurated ulcers) are not amenable to medical treatment. I have shown that in this series of fifty cases some such condition was found in 40%, previous to operation, and I believe there is at least another 10%, "border line cases," that cannot be detected until explored, so that of the class of ulcer cases coming under my observation in this locality at the present time, about 50% should be treated surgically, because they probably cannot be cured by any known medical treatment. From the foregoing statement it must be evident that a wise selection of cases must be made if any considerable percentage is to be cured by proper medical treatment. By proper treatment I mean the intelligent application of that method which seems to best meet all of the essentials to a medical cure.

It is quite universally agreed that the essentials to a medical cure are (1) rest for the stomach, probably for not less than fourteen days; (2) the suppression or neutralization of the gastric juice; (3) the administration of sufficient nourishment, so that there will be but little or no loss of weight. I allow you to judge wherein our older methods fail to meet these requirements. I have already stated my objection

to the Lenhartz treatment. I abandoned the Leube method some time ago, after a number of years' experience with it. I then sought the aid of surgery for the relief of all classes of ulcer until about three years ago, when I became acquainted with duodenal feeding, as introduced by Einhorn. This is a comparatively new method of treatment and little is known of it. Its results in the treatment of ulcer are not generally known, because none have been published up to the present time. Like any new method, this one is probably looked upon with skepticism by many. This much I have learned from my experience with this method of treatment in ulcer, (1) ample nourishment may be furnished the patient for an indefinite period; (2) gastric acidity, even when present in excessive amounts, is reduced to a negligible quantity or to nil, as I have repeatedly determined in different patients during treatment, and (3) while we have no method of determining the state of peristalsis, it is fair to assume that it is in a state of practical rest, as occurs in prolonged fasts; moreover we know that the stomach contracts, thereby helping to prevent bleeding and perhaps aiding in the process of healing. All subjective symptoms usually subside within 24 hours. Many cases of ulcer have been cured by methods possessing less merits than duodenal feeding, consequently in well selected cases I believe this method will show a large percentage of permanent cures.

My clinical experience with this method is too limited to warrant saying much about cures. I offer the following merely as a preliminary report.

Of sixteen cases treated in the past two and one-half years, I exclude the following cases: Case 1 (Table No. 2) died several months after treatment, as a result of a surgical operation for another condition. Case 3 proved not to be ulcer (previously mentioned). Case 5 excluded for good reasons. Case 11 had organic stenosis and should not have been treated. I have advised surgery. Case 14 I considered surgical and so advised, both before and since treatment.

Of eleven cases which may be counted, three are entirely well more than two years since treated. Four other cases are equally well more than one year since treated, and two others are free from symptoms several months after treatment. In two cases, with complete relief from symptoms, the ulcers did not heal (as shown by positive thread tests), or at least were open soon after treatment. So that up to the present time, I have encountered two failures in eleven cases, or in 18%, a percentage, by the way, not equalling the surgical mortality here reported in the fourteen operated cases. The mortality in the seventeen cases treated medically was nil.

But what is the reason for this 18% of failures? Were they due to some fault of the method or its application, or to an improper selection of some cases not amenable to medical treatment of any kind? In my opinion they were due to the latter cause. Thus far only one of my uncured cases has come to operation, although operation has been advised for all.

This case, a man of 57 years, had digestive symptoms 38 years, and in the past six years had undergone two laparotomies, one for an appendix, and later one for adhesions. I diagnosed duodenal ulcer, and considered it an uncomplicated case. Two months after treatment there was a recurrence of symptoms and a positive thread test. Operation revealed a duodenal ulcer $\frac{3}{4}$ -inch across, several adhesions, and some pyloric stenosis (although tests for stenosis before treatment failed to show any). The patient died within forty-eight hours. The other failure was in a boy of 14 years, with a duodenal ulcer of seven years' duration, and I considered it uncomplicated. Symptoms recurred within two weeks. Operation is pending. I class these two cases with that certain percentage of "border line" cases in which contraindications to medical treatment cannot be determined before treatment.

Based on this experience with fifty cases and upon statistics obtained from various sources, I present for your consideration the following conclusions: (1) Of one hundred patients with peptic ulcer as met to-day, with an average age of forty-seven years, and an average duration of the ulcer exceeding fourteen years, about ten cases will have become malignant. (2) Of the remaining ninety cases about one-half, or forty-five cases, will demand surgical treatment, and we may expect an immediate mortality, by the average surgeon, exceeding 15%, or about seven cases, and of the thirty-eight cases surviving operations about 80%, or thirty cases, will be cured. (3) Of the remaining forty-five cases all may be treated medically with a mortality of less than 3%, or one case, and possibly 75% of cures, or thirty-four cases. The ten uncured cases may later receive the benefits of surgery with its mortality of two cases, and 80% of the eight cases, or seven cases cured. So that of one hundred cases, about ten will have become cancerous, surgery will cure about thirty-seven, medical treatment will cure about thirty-four cases, or a total of seventy-one cured by combined medical and surgical treatment; one case may die during medical treatment, and nine as the results of surgery, and about nine cases will remain uncured.

Could ulcer cases be recognized within the first three or four years

of the disease, a much smaller percentage of cancer would probably be met, and most cases might be treated and cured medically.

The boy of 14 years, uncured by duodenal-feeding, was operated, a gastric ulcer was found but no reason could be found why it did not heal. The patient died in about two weeks from persistent vomiting. This is the fifteenth case operated on to date and the fifth death resulting therefrom, a mortality of $33\frac{1}{3}\%$.

TABLE NO. I.

SURGICAL AND OTHER CASES NOT TREATED BY DUODENAL FEEDING.

No.	Sex.	Age.	Duration, Years.	Kind.	Pyloric Stenosis.	Blood.	Cancer.	Treatment.	Result.
1	M.	39	5	Pyloric	+	0	0	Surgical	Good
2	M.	46	5	Duodenal	+	0	0	Surgical	Good
3	M.	48	15	Pyloric	+	0	0	Surgical	Good
4	M.	51	25	Pyloric	+	0	0	Surgical	Good
5	M.	46	31	Duodenal	+	0	0	Surgical	Good
6	M.	54	5	Pyloric	+	+	?	Surgical	Good
7	F.	65	40	Pyloric	+	+	0	Surgical	?
8	M.	41	10	Pyloric	+	+	?	Surgical	?
9	M.	58	28	Pyloric	+	+	+	Surgical	Dead
10	M.	46	20	Pyloric	+	0	0	Surgical	Dead
11	M.	48	10	Duodenal	0	+	0	Surgical	Dead
12	M.	57	38	Duodenal	?	+	0	Surgical	Dead
13	M.	51	20	Gastric	0	+	+	Surgical	Dead
14	F.	36	10	Gastric	+	+	+	Surgical	Dead
15	F.	44	4	Pyloric	+	0	0	None	Dead
16	M.	54	30	Pyloric	+	0	0	None	?
17	M.	71	10	Pyloric	+	0	+	None	Dead
18	M.	59	15	Duodenal	0	0	0	None	Living
19	M.	42	3	Duodenal	0	+	0	None	
20	M.	54	25	Duodenal	0	0	0	None	
21	F.	23	10	Gastric	0	+	0	Medical	Poor
22	M.	51	25	Duodenal	0	+	0	Deferred	
23	M.	51	3	Gastric	0	+	0	Deferred	
24	M.	43	1	Duodenal	0	+	0	Deferred	
25	M.	54	10	Duodenal	0	0	0	Deferred	
26	M.	25	3	Gastric	0	+	0	None	
27	F.	27	8	Gastric	0	+	0	None	
28	M.	28	5	?	0	+	0	Medical	Good
29	M.	53	10	Pyloric	0	+	0	None	
30	F.	55	10	Gastric	0	+	0	Medical	Poor
31	M.	57	8	Pyloric	0	+	0	None	
32	F.	31	2	Gastric	0	+	0	Deferred	
33	M.	43	1	Gastric	0	+	0	Deferred	
34	F.	30	6	Gastric	0	+	0	None	
35	M.	45	12	Gastric	0	+	0	Surgical	Living
36	M.	56	8	Pyloric	+	0	?	Surgical	Living

TABLE NO. II.
CASES TREATED BY DUODENAL FEEDING.

No.	Sex.	Age.	Duration, Years.	Blood.	Pyloric Stenosis.	Hyper- secretion.	Kind.	Result.	Months since Treated.
1	M.	48	10	+	0	50 c. c.	Duodenal	Good	29
2	F.	37	9	0	0	0	Pyloric		
3	M.	28	5	0	0	200 c. c.	Duodenal		
4	M.	32	14	0	0	120 c. c.	Duodenal	Good	27
5	M.	52	16	0	0	0	Gastric	Good	26
6	M.	34	1	+	0	150 c. c.	Duodenal		
7	M.	29	10	+	0	0	Duodenal		
8	M.	77	12	+	0	200 c. c.	Duodenal	Good	14
9	F.	48	20	+	0	0	Gastric	Good	12
10	M.	22	4	0	0	150 c. c.	Gastric	Good	12
11	M.	64	10	+	+	200 c. c.	Duodenal	Poor	8
12	M.	57	38	+	?	0	Duodenal		
13	M.	53	30	+	0	0	Gastric		
14	F.	42	15	+	0	0	Gastric	Poor	2
15	M.	14	7	+	0	0	Duodenal		
16	M.	49	6	+	0	0	Pyloric		

Cases 1, 3, 5, 11 and 14 not considered for reasons given.

Cases 1 and 12 became surgical cases.

DR. SPALDING: We shall be very glad to hear from Dr. Twitchell in regard to the discussion of this paper.

DR. TWITCHELL: Mr. President and Gentlemen: I am sure we all feel grateful to Dr. Chase for giving us such a concise and practical paper. Conservation of life and usefulness is the reason we are discussing this subject. You all remember, all of you gentlemen of my youth, how much trouble we had years ago with appendicitis—how great the mortality was—and it was only after the internists began to recognize the cases and send them to the surgeon early that we began to reduce that mortality. The same thing has obtained in regard to gastric and duodenal ulcers. Some few years ago all the operating that I did, about all the operations at the Maine General Hospital, upon gastric ulcer were simply exploratory incisions, because when we got inside the conditions would be so gross that nothing further could be done. It is especially true of this disease, that the more readily the diagnosis can be made the less hopeful is the treatment. In order to do these cases any good surgically we should have them early. Within the last ten years, particularly, we are getting these cases sent to us early enough so that we can operate on them more successfully. Now the question, as I say, is one of conservation. Can it be better accomplished by purely internal treatment, or can it be better accomplished by purely surgical treatment, or, rather, by a combination of the two methods? I think we all agree that it is a combination—team work between the internist and the surgeon—that the best results can be obtained.

Now cases, to my mind, that should be operated upon are, first, cases that present obstruction to the outlet of the stomach; second, cases of recurrent, somewhat severe, hemorrhage, and third, cases where there is frequent recurrence of severe symptoms, either with or without hemorrhage. These cases suggest such gross lesions that medicine alone cannot cure them and they need surgical treatment.

I want to make now a few remarks on this point about the method of surgical treatment. Of course the literature on this subject is available to all of you, and so I will not go into a discussion at all of the operation, but a few things have occurred to me in my experience that may be of interest to you. I used to put in a non-absorbable running ligature for the outside stitch, but it was found that the non-absorbable stitch became a source of irritation about the stoma amastomosis, causing some pain and recurrence of other symptoms. Now if we use a non-absorbing ligature, it is better to put in interrupted sutures so small that they will be taken care of by the tissues. That is one important point. Of course, if you want to put in for your inner stitch a non-absorbable running suture, you can do so, because it will probably work its way out in time and pass down, but we have received aid from the laboratories in this matter by having produced sutures which are absorbable. The best that I have seen, and I do not know whether it is familiar to all of you, is Luken's tannin-cured absorbable ligature. That comes with an inside weld to the thread. These have a needle on each end, but I should not care for a needle except on one end, although it is somewhat useful to put in a cobbler's stitch in the first part of the second row, which checks hemorrhage.

In the most of these cases that we see of peptic ulcer, we treat them by Phinney's method of making a larger pyloric opening. It is very rarely that one finds a case where that operation is useful, because the scar of the ulcer is apt to be so near the duodenum that it would be involved in the suture, so that we usually make a posterior gastroenterostomy. Occasionally there will be a case where it would be necessary to make a partial gastrectomy. If you put in a double row of stitches to close the stomach incision, you do not leave enough gastric healthy surface so that you can make a posterior gastroenterostomy. Anti-colic jejuno gastrotomy gives very good results. Instead of closing up your stomach wound separately, you bring only the jejunum up, and stitch it the whole length to the gut end of the stomach. That saves putting an extra row of sutures in the stomach, and it conserves the stomach for future usefulness.

One thing more. There are a lot of these cases floating about the country without proper treatment, and I had an experience this week with a case that illustrates this point. We operated on a man a week ago to-day who had a history of some fourteen years of gastric ulcer. He had an explanatory incision a year ago last July, and his stomach showed the largest saddle ulcer scar that I had ever seen, larger than a silver dollar, which had healed. He came to us with an annular constriction of the pylorus from ulcers, associated with a gastric ulcer, so that the stomach was holding about three quarts. He was a walking skeleton. We did not think he would stand much of an operation. We tried to build him up, but he lost four pounds in one week while we had him under treatment. I speak of this case because the man is a type of cases floating about the country year after year, and no one is treating them correctly. The symptoms of such cases, briefly speaking, are these: They have frequent recurrences of indigestion, and they are treated for indigestion; that is all the

treatment they get. They go from one doctor to another, and they are useless to the community and should be treated surgically. Now if any of you know of people in your community who have been chronic dyspeptics for a long time, consider whether they do not belong to this class and should be sent to the surgeon.

CHAIRMAN COOMBS: If Dr. Tobie is present, we should be very glad to hear from him.

DR. TOBIE: Mr. President and Gentlemen: I appreciate the value of Dr. Chase's work, and in particular his work in diagnosis. I have found him helpful a great many times, but it is very difficult for me to believe that any form of medical treatment will permanently cure gastric ulcer. I cannot see how it can with any degree of assurance. It seems to me that, if we have a gastric ulcer, the proper treatment is gastroenterostomy. It may be that by means of treatment such as the doctor has outlined, we will hold that ulcer for a time. If we hold it, we leave a scar, and it seems to me that there is very strong probability that such a scar may give rise to a cancer later on. This is true of gastric ulcer. When we have cancer of the duodenum, it is a cancer which has probably originated in the stomach and has traveled over to the duodenum.

In addition, it seems to me that this operation is of great value for other conditions that may be present. I have never been able to positively determine always (sometimes we can) that the condition was a gastric ulcer. Of course we have these means of diagnosis, but sometimes they fail. I have at operation discovered a very large gastric ulcer which I had suspected, and which I believed to be present, and I diagnosed it by the history; and it seems to me that, on the whole, the history of these patients is the most valuable means of diagnosis that we have. We have the X-ray, but sometimes that fails. So, now, it may be that if we perform tests enough, and perform them often enough, it will be possible for us to state quite positively what we have; but we cannot always do that. Now supposing we have made a mistake. Of course we will throw out cases of functional disturbance—functional indigestion. We may have appendicitis, and, if we have it, the appendix may be removed at the time of the operation; perhaps there is some trouble with the gall bladder, and you remove that. There may be adhesions due to an old gall bladder trouble. It seems to me that the operation is a cure for all these stomach troubles, with the exception of the one that it was first employed for, cancer of the stomach, and for cancer of the stomach I should say that gastroenterostomy was very rarely indicated. It may prolong life a little; the chances are that it won't. They say the patient will die more quickly if he has an operation. If you have ulcer of the pylorus, you may do an operation for that and prolong life a considerable length of time. I think, however, that even in those cases it is doubtful. I should say that gastroenterostomy was rarely indicated for the stomach.

In cases of this sort I do not advise exploratory operations. We sometimes operate in these cases with a hope that it is a thickening of the pylorus, a sort of fibroid stenosis, and if we operate for that and perform a gastroenterostomy there will be a cure. The late Dr. Alfred King operated—and I was with him at the time—for what he believed to be cancer of the pylorus, and he contended for years that he had cured that man by means of gastroenterostomy. I believed it for a while, and then I dismissed it altogether. I discussed it with him from time to time, but he insisted that he had cured him.

The man lived for fourteen years and then died. There was an autopsy, which disclosed an old ulcer, a sort of fibrosis. So I think that sometimes, if there is an element of doubt, we may operate for what is said to be cancer of the stomach. If you believe it to be cancer of the stomach, I should not advise it. If you think it gastric ulcer, gastroenterostomy has been in my observation practically always a cure. There is an element of chance that you have to take in all these cases. However, I recognize the great value of Dr. Chase's treatment, and I appreciate the courtesy in allowing me to discuss it.

CHRONIC GASTRIC LESIONS.

By DR. B. L. BRYANT, Bangor, Maine.

This paper will attempt to discuss the chronic lesions of the stomach, peptic ulcer, both gastric and duodenal, and cancer, bringing in also in brief those conditions which so simulate these gastric lesions as to oftentimes make the certain diagnosis an extremely difficult one. The material for this paper has been gathered from somewhat extensive reading, from recent observation of cases and treatment in the clinic of Dr. Sippy, of Chicago, in the Mayo clinic of Rochester, and from personal experience in private practice and a considerable hospital clinic, where I have been able to follow the case over extended periods and through many operations. I shall deal very little with theory, but shall confine myself for the most part to well established facts, and shall close the paper by presenting a few selected cases to illustrate the facts I have attempted to bring out.

Rosenow has made it very clear by his oft-repeated experiments that many lesions of the stomach are caused by focal infections, especially of the teeth and tonsils, that various strains of streptococci have a selective action for different areas and organs of the body. Cultures made from abscessed teeth or tonsils from many of the cases suffering from peptic ulcer when injected into animals will cause the same stomach lesions. There is little doubt that many cases of ulcer of the stomach are secondary to infections in the mouth, the abscessed teeth and tonsils. Probably other areas of focal infection in the appendix, gall-bladder, intestine or other parts of the body may play a part. Of other presumptive causes of ulcer, like food trauma and anemia, we

have no absolute proof, but without doubt there are many other agents which are causative in breaking down the mucous membrane and establishing a lesion.

Gastric and duodenal ulcer must for the most part be classified together, as the first part of the duodenum is structurally the same as the stomach. About 75% are beyond the pyloric ring, leaving but 25% in the stomach itself.

In making a diagnosis of stomach lesions the physician must keep in mind that the pathological conditions which cause gastric disorders may be due to various lesions, either local, focal or reflex, or to general infections. There are a multitude of causes for upper abdominal pain, and if one's mind is fixed upon gastric diseases alone he may miss entirely the gall bladder, the pancreas, the appendix, the kidney, or many other conditions which are interpreted by the patient as stomach trouble. Tuberculosis, cardorenal disease, syphilis, meningeal tumors, cord irritations, and many others, though remote, hold the stomach in their train of symptoms. So in the diagnosis the clinical history holds the first place. Second in the hands of the expert, the X-ray. In the hands of the novice it is very misleading. The owning of an X-ray apparatus does not make an expert. The intelligent interpretation of plate or screen to be of value must be the result of many years of experience with a large number of cases. The value of the third factor in diagnosis, the chemical examination of test meals and feces, the observation of motor tests, depends to an extent also upon the expertness of the observer, or whether or not the physician has an expert X-ray man upon whom he can depend. These findings should not be entirely disregarded, and should as a routine be made part of the clinical diagnosis.

In my own work the routine is somewhat as follows: First there is a careful history with a thorough physical examination. The patient is then requested to present himself early at the hospital without breakfast, where an Ewald meal is at once given and aspirated at the end of fifty minutes to one hour. This is sent to the laboratory. The X-ray meal is then given, two to four ounces of barium in one pint of corn-starch gruel, flavored to taste. The first picture is then taken, followed by others in succession, the last six or seven hours later. The laboratory work, urine, blood, feces and stomach contents are completed in the meantime, so at the end of twenty-four hours we have most of our evidence in hand. If this is not clear, further plate fluoroscope or chemical work is done.

To make a clear diagnosis of peptic ulcer it is of the utmost importance that the history should date back to the very first symptom.

for many cases which give an early typical history become more complex and atypical as the disease advances, and would be very confusing unless the early history is kept fixed in mind. In the history of ulcer there are no fixed symptoms or group of symptoms that always warrant the ulcer's location. For instance, in the duodenal type about 75% give us a fairly typical duodenal history, 25% fall into the gastric type. In the history of gastric ulcer 25% are of the typical duodenal type, leaving 75% to fall into the gastric type. Neither does pain as to kind, severity or location point clearly. The kind of pain or control gives us clear points but not positive evidence. An ulcer near the pylorus will give about the same symptoms regardless of the side it is on.

In a short paper like this the classification of types can only be briefly made, with the understanding that there may be 25% or even larger error either way, according to the expertness of the clinician in taking gastric histories. Duodenal ulcers, as a rule, have longer histories. The classic symptoms of Moynihan point out fairly clearly the ulcer of the duodenal type. Hunger pain, pain from two to five hours after eating completely relieved by taking food, tenderness over the duodenum, a relatively high acidity with free hydrochloric normal or above, blood in the stools in about 25% of the cases, and finally in a large per cent. in the later stages the evidences of obstruction. Gastric ulcer is apt to have shorter attacks. The pain may come on earlier after food is taken, is less apt to be relieved by food, or may be relieved by small amounts of bland food and increased by large amounts of coarse food. Often there is regurgitation of hot or sour water, hemorrhage more often present. The pain may be higher up and more to the left. Large ulcers seem to give more continuous symptoms, food more apt to give immediate distress and the patient is easier with the stomach empty. Small ulcers with high locations often give clear-cut duodenal histories. So there can be no hard-and-fast rule as to location. The chief object is to determine the presence of a peptic ulcer that the patient may be relieved by the proper medical or surgical treatment.

In the clinical diagnosis of ulcer, other common conditions must be kept constantly in mind. First, gall-bladder disease and gall-stones. Often this condition is more or less latent. While there are vague symptoms pointing to the liver the gastric symptoms predominate. They are made up of practically the same elements as in ulcer, pain, gas, vomiting, periodic in a sense, but with a quite different grouping. Pain appears suddenly, usually of short duration and without warning, and disappears as suddenly, and the patient returns to normal health. The

pain is the great and constant symptom, more often epigastric but may radiate to the back and may be severe, approaching the pain of a gastric perforation. This pain comes, in most cases, entirely without relation to food, not caused or relieved by it in the majority of cases. There is another class of very mild cases when the trouble comes on suddenly, where there are slight attacks of distress or gas pressure coming at irregular times, but often with some relation to food. There may be some slight regurgitation or vomiting. These may pass off without much disturbance or treatment, but these mild dyspeptic attacks are just as characteristic of gall-stone disease as the major ones.

In the differential diagnosis of chronic appendix from ulcer, especially duodenal, there should not be much difficulty, notwithstanding the fact that there is a peculiar relation between the two conditions which is not well understood. Why in a large number of cases of duodenal ulcer the appendix should be found diseased, or why a chronic appendix should give clear-cut symptoms of duodenal ulcer we do not know, unless it is a part of the syndcondrome of focal infection. But the fact remains that even in the best clinics patients set down for an operation for duodenal conditions are completely relieved by the removal of a chronic diseased appendix. So close is this relation, in all cases of duodenal operation the appendix should be explored and removed in the younger adult whether ulcer is found or not.

Cancer of the stomach.—The minds of scientific medicine are beginning to crystallize about the fact that cancer is due in great part to unrelieved chronic inflammations. There is no doubt but that a great majority of cancers of the stomach are due to chronic untreated gastric ulcers. In some clinics it is held by the pathologists that all cancers of the stomach removed have as a base the edge of a gastric ulcer. It is a peculiar fact that very few, if any, duodenal ulcers become cancerous, and that even the cancers of the pylorus rarely develop beyond the sphincter into the duodenum. In making the diagnosis of cancer of the stomach the age of the patient is of importance. The history of many cases of cancer is that of chronic peptic ulcer. In the more advanced stages there may be irregular dyspeptic symptoms, progressive weakness, loss of weight, with beginning secondary anemia. A constant diminution or absence of free hydrochloric acid should make us suspicious, and the presence of a tumor, with bleeding, will clinch the diagnosis. But if the diagnosis is not made before these later stages, as far as the welfare of the patient is concerned, it may as well not have been made at all, as it is too late to give him relief.

X-ray diagnosis.—The X-ray has its strong points and its limitations in the diagnosis of stomach conditions. While it is compara-

tively easy to get good pictures, the reading or interpretation is a matter of the greatest importance. Only the opinion of those having a large experience can be of value. An amateur can read almost any diagnosis from a plate, especially the one he wishes to confirm. Röntgenograms are but the shadows of a barium-filled stomach upon a photograph plate. Lesions are diagnosed by the constant irregularity of outline found in several exposures, and great care must be taken to differentiate these from the normal peristaltic waves. Gastric ulcers appear in two forms, those that make a niche in the outline, and those where craters are filled, making an outward protrusion. In duodenal ulcers, when in the first part of the duodenum, the so-called cap, the presence of an ulcer will show a deformity in outline, or failure to fill with increased peristaltic action, leaving a considerable residue in the stomach after the normal time of emptying. Sometimes much better results can be obtained in duodenal work with the fluorscope screen, where the barium can be pressed into the cap by the hand and the outline seen at once or by the use of numerous successive plates, like a moving picture, according to the method of Cole. In cancer of the stomach, especially in somewhat advanced cases, these outline changes are more marked. Certain portions of the stomach, especially along the lesser curvature, become infiltrated and remain unchanged during the peristaltic wave, or show certain finger-print markings or hour-glass deformities. But to be of value they must be found constantly in several successive plates. Many clinicians and X-ray operators will tell you that they can diagnose stomach lesions in the precancerous stage. This is hard to believe, for if the specimens were removed and placed on the table before them they would be unable to distinguish the infiltrated chronic ulcer from the one in the precancerous stage without a microscope examination.

The whole theory of the treatment of peptic ulcer is, that if the cause of the irritation be removed the lesion would heal like a sore in any other part of the body. This irritating agent is supposed to be the hydrochloric acid or the digestive action of the pepsin in its presence. The usual medical treatment is rest in bed, at first on a low diet, with sufficient alkalies given to keep the secretions constantly alkaline. The method of Sippy is possibly the more scientific. Beginning at 7.00 in the morning, a powder containing ten grains of calcined magnesia and ten grains of sodium bicarbonate is given; at 7.30, an ounce and a half of milk and cream; at 8.00, a powder of ten grains of calcium carbonate and thirty grains of sodium bicarbonate; at 8.30, the cream and milk, at 9.00 the first powder, and so on through the day until 9.00 P. M. At 4.00 P. M. the contents are tested, and if found acid the

amount of bicarbonate is increased. At 10.00 P. M., if the contents are found acid they are withdrawn and the stomach washed out. Nothing is then given until 7.00 the next morning. Powder number one has a neutralizing power of sixty grains of soda bicarb, but the magnesia acts as a laxative, so the second containing the calcium carbonate is alternated. This has a neutralizing power of fifty-five grains. After a few days' testing, the amount of alkali needed to keep neutral the contents is found and the testing is stopped. The patient is kept in bed for at least four weeks. After the first week more food is added at the regular meal time until the patient is taking a fair meal, with the milk and cream between times. When discharged from the hospital he is eating his usual three meals, followed by a double powder, with milk and cream at ten and three, followed by another double powder. This is kept up for a considerable time. All symptoms usually disappear at once after the stomach contents are permanently neutral, and there is no necessity for either rectal or duodenal feeding. I have no doubt but that a large percentage of ulcers are healed in this way. But we must keep constantly in mind that it is the nature of peptic ulcers to have intermissions and the patient enjoy good health sometimes for months and even years without treatment. The most frequent time for appearance is in the fall or spring, or when the patient becomes tired or run down by too much work or worry. I believe that every patient, especially in the early stages, should have a faithful trial of medical treatment extending over several weeks. Then if the recurrence becomes more frequent or the obstruction increases the case should be turned to the surgeon for operation, keeping in mind that nearing the cancer age gastric ulcers are prone to become malignant, and others may perforate. The former must be cured before they enter the precancerous stage.

In the Mayo Clinic, after long observation, 65% cures are reported, 20% much relieved, 9% not relieved by gastroenterostomy. In conclusion, I wish to say that personally, if I should have pain and bleeding from the stomach and suspect an acute ulcer, I should put myself into the hands of the best clinician I could find, and have him use every means to make a diagnosis of location, both laboratory and X-ray, then I should go on medical treatment with fair expectation of recovery. But if there should be succeeding attacks at shorter intervals at my period of life, which is in the cancer age, I should pick out my surgeon and have an exploratory operation, and leave it to him to decide while inside what was the best to do. The honest rule should be that as soon as you are convinced that there is a surgical lesion in the upper abdomen, which does not readily yield to medical treatment, a surgical

operation is not only indicated but in many cases imperative. At the time of the operation, not only the stomach, but the gall-bladder and appendix, the kidney, and in fact the whole abdomen, should be explored. If a duodenal ulcer is found a gastroenterostomy should be performed; if gastric, it should be excised and gastroenterostomy done at the same time.

In stomach work the physician and surgeon should get closer together and work for the best interest of the patient, and not for the upholding of their own special methods of treatment or diagnosis. Neither side holds all the cards, and for the patient's good, both hands should be placed face up on the table.

During the past few years, I have been fortunate in finding among my cases nearly all the types, including complicated conditions of gall-bladder appendix and perforation. A majority of these have come to operation by Dr. Simmons and the diagnosis confirmed. I am presenting with these prints from the X-ray plates. Of course these are not as satisfactory as the illuminated plate itself or the lantern slide, as the fine markings cannot be brought out.

CASE I. F. S., male, farmer, age 46. Family history negative. Always hard working; little illness. No venereal disease. Has had occasional spells of indigestion. Present illness—For a number of months has had daily distress in stomach, pain coming on about 11.00 in the morning and 4.30 in the afternoon. A glass of water or a little food will generally give relief for a time. Has occasionally vomited. Has lost some weight. Test meal, 150 cc. containing food particles and mucus. Free Hydrochloric 37, combined 32. No microscopic blood. Diagnosis—Ulcer near the pylorus with slight obstruction. Recovery under medical treatment.

CASE II.—O., lumberman, age 45. Always been a hard-working man, with periodic attacks of stomach trouble. Present illness—About four weeks ago was working in the woods rolling logs on to a sled. Was pushing a log to the top of the load when he felt a sudden pain in the stomach region, began to have pain after eating, usually in one or two hours. Very severe. Relieved for a time by eating. Very constipated and lost twenty pounds in two weeks. Could not eat any solid food. Tall, thin man; very weak. Pain and tenderness a little to the right of the umbilicus. No mass felt. Large amount of fluid found in stomach removed by tube. Hydrochloric normal. X-ray shows no barium passing from the stomach. Twenty-four hours after practically all the barium was recovered by the stomach tube. Diagnosis—Chronic ulcer of the duodenum. Treatment—Rest in bed, milk

and cream diet with alkalis and bismuth, daily washing. Continuous improvement. In two weeks was eating solid food with no discomfort. Saw him six months later seemingly entirely well. One year later, old symptoms returned and a gastroenterostomy was performed. Recovery.

CASE III.—Miss E., Spinster, aged 40. For several years has had stomach attacks, especially when overworked and run down. Present illness has continued over some weeks. A great deal of distress a few hours after eating. Relieved for a time by taking food. Nervous, thin and anæmic. Abdomen flat. Stomach much enlarged, extending into the pelvic region. Tenderness a little to the right of the umbilicus. No mass felt. Considerable brownish fluid removed with the tube. But little barium had passed from the stomach in six hours. Operation—Pylorus found somewhat thickened and almost closed. Posterior gastro enterostomy. Complete recovery. Eating solid food within one week.

CASE IV.—E. H., laborer, age 35. Has had trouble with stomach for two years, commencing with heartburn and a broiling up in stomach. Contents very sour. Vomits when stomach gets full, undigested food eaten days before. No blood, and no pain in stomach between meals excepting when it gets filled. Then vomiting relieves. Tenderness over mid-epigastric region. No tumor felt; temperature normal. Test meal, 700 cc. thin, brownish fluid, food particles, small amount of mucus. Free hydrochloric 38, combined 20. Positive blood. Treatment—Was kept fairly comfortable for some days with lavage and alkalis. Diagnosis—Pyloric obstruction. Operation—Stomach found involved in a tubercular mass and many adhesions about the pylorus. Posterior gastroenterostomy. Recovery.

CASE V.—M. L., male, age 49. Gives a history of stomach trouble extending over many years, pain being the most marked symptom. This has not been connected especially with the taking of food, but comes on when he works and is referred to the stomach. For the past fourteen months has not been able to work. Cannot ride in his wagon without pain. Has lost fifty pounds in weight during the past year. His physical examination shows some rigidity in the upper right quadrant and tenderness over the stomach and appendix region. The X-ray gives a somewhat irregular-shaped stomach, but nothing definitely abnormal, emptying itself in normal time. Stomach contents—Free hydrochloric 3, combined 43. Urine, blood and fæces normal. Diagnosis—Chronic appendix, possible malignant disease. Operation revealed a chronic appendix, and in the mid-line over the stomach a small epigastric hernia, a mass of fat about the size of a walnut protruding

through a small opening in the fascia with no connection with the abdominal cavity. This was removed, together with the appendix, with complete relief of symptoms.

CASE VI.—J. Mc., painter and carpenter, aged 28. Never sick abed. About six months ago began to complain of pain in the stomach, which has gradually grown worse. Pain begins from one to two hours after eating and continues until he eats again. A little food will relieve for a short time. Never vomits, no blood in stools. Pain and soreness a little to the right of the mid-line, below the gall-bladder, never colicky or sharp. Has lost twenty-five pounds in weight. Stomach contents, 20 cc. greenish fluid. Free hydrochloric 8, combined 30. Blood negative. Later some tenderness developed in right lower quadrant. No evidence of pyloric obstruction. Operation—Appendix removed. Recovery.

CASE VII.—M. L., canoe maker, age 47. Mother died of cancer of the stomach. Has had some spells of indigestion. Present illness extends over a few weeks. Complains of pain in the pit of the stomach and distress. By putting his finger down his throat he relieves himself by vomiting. Never vomits unless forced. Vomitus undigested food, free from blood, but bitter and burns mouth and nose. Pain comes on sometimes after eating. Hypodermic of morphia is followed by a gurgling sound and relief. Has lost considerable weight. Constipated. Appetite fair. Pain and resistance in whole epigastric region. No mass felt. Test meal, 300 cc. thin fluid with food particles. Free hydrochloric 48, combined 32. No blood. X-ray shows some residue after six hours. Diagnosis—Slight obstruction of pylorus due to gall-bladder disease. Operation—Gall-bladder filled with stones, some adhesions about pylorus. Gall-bladder drained. Complete recovery.

CASE VIII.—R. W., housewife, age 27. Had had appendix and uterus removed. Illness dates back five years, when patient began to vomit. Unable to keep much of anything on stomach. Never vomited much blood, occasional streak in severe vomiting spells. No pain in stomach, but a continuous hunger sensation, so tries to eat every few hours. Constipation, alternating with diarrhoea. Very emaciated. X-ray shows hour-glass stomach. Operation—Stomach found divided by a long stricture. The upper half very thick and leathery. Stricture cut out and the two parts united by suture. Left hospital eating house diet, and has remained well.

CASE IX.—Housewife, age 40. Mother of five children. Bothered with stomach since a small girl. Present illness—Five weeks ago be-

gan to have pain in stomach and regurgitate hot water. Came on rather suddenly. Pain almost constant. Increased by food. Considerable gas. Very constipated. Lost much weight. Face thin, skin yellowish. Pain and tenderness in mid-line about on a level with the umbilicus. No mass on palpation. X-ray shows an hour-glass stomach. Operation—Hard infiltrated mass felt near cardia. With a number of enlarged lymph glands near the stomach. Posterior gastro-enterostomy. Symptoms relieved. Operative diagnosis carcinoma of stomach.

Necrology.

MAJOR HARRISON BRIGGS WEBSTER.

CASTINE.

AN APPRECIATION BY DR. R. W. WAKEFIELD, BAR HARBOR.

Among the many brave New England men who have made the supreme sacrifice on the soil of France within recent months none deserves greater mention than Major Harrison Briggs Webster. So



quiet and unassuming was he in his splendid work here in Maine that few knew his real worth, and it is for that reason, together with my love and great admiration for the man, these lines are written. I fully realize that no words of mine can enhance his value to those who really knew him.

Harrison Briggs Webster was born in Boston, January 26th, 1884, the son of Andrew and Florence Briggs Webster. He attended Noble and Greenough School until he entered Harvard University, from which

college he graduated (*cum laude*) in 1905. He belonged to the Phi Beta Kappa fraternity. Graduating from Harvard Medical School in 1909, being president of the class, he served as interne at the Massachusetts General Hospital, Boston, and the Bellevue Hospital, New York.

Upon completion of his education he went with the Grenfel Mission in Labrador and Newfoundland, and in the latter place established one of the hospitals of the Association. During this work he and Dr. Grenfel became warm personal friends, and it was with the greatest regret of the latter that Major Webster returned home after about two years of service. After spending a summer along the Maine coast on the mission yacht "Sunbeam", rendering very efficient service to the fishermen on the islands and small hamlets, in 1913 he married Miss Margaret Gleason and established himself in practice in Castine, opening a small hospital. Instead of settling in his native city, where his thorough education and marked surgical skill would have assured him success, he chose rather to serve the people along the Maine coast who could not otherwise obtain expert medical and surgical care.

Always an ardent advocate of national preparedness, he lost no time in entering the first Plattsburg Officers' Training Camp in 1916. He attended the second Plattsburg Camp in the summer of 1917 and was soon commissioned First Lieutenant in the Medical Reserve Corps, although he was very keen to be commissioned as a line officer. In June, 1917, he was ordered to Fort Benjamin Harrison to join the ambulance service, and after a few days was made Captain of his company. While at Fort Harrison, in coöperation with the battalion Commander, Major Bastion, he reorganized the ambulance service and worked out the details of procedure in actual combat. It was Capt. Webster's company that demonstrated the workings of the ambulance service to the medical officers receiving military training. His great enthusiasm, hard work and marked executive ability won him high praise from his superior officers. In November, 1917, he and his company were ordered to Camp Greenleaf, Fort Oglethorpe, Ga., and after reaching there he was shortly made Adjutant of the battalion. In the spring of 1918 he received his Majority, thus receiving three commissions within a year. In May he sailed for overseas, and for a time after reaching the other side was Director of Ambulances, but, desiring more active service, was soon made Regimental Surgeon of the 47th Infantry.

To show the quality of his service in France I take the liberty to quote from one of his letters sent home just before his death. His regiment had gone into action and he and his men were following along to take care of the wounded.

"The regiment had got ahead of us and the first thing we ran into in the fog was a party of twenty prisoners, one wounded, coming to the rear. We went the whole length of the regimental front and found only a few prisoner squads and a couple of American wounded walking cases.

"Then we started forward over the ridges, and we could hear the barrage rolling along ahead and the machine guns cracking away in the fog. When we got up on the first ridge we could see a little, but no wounded—just deserted trenches and wire. I had found a big pair of double purchase German wire cutters and went ahead, cutting away through line after line of wire and the poor old stretcher bearers pushing the carts along over that rough ground were getting slower every slope we climbed. Finally, we got to the slope in front of the town we were to take and the fog had lifted, so we could see even over to the next hill where the regiment on our left were attacking.

"I went up the ridge to look into the next valley and near the top ran into a little squad of stragglers hiding out in a trench. I asked them why they were not with their company and they said they were lost and the machine guns were playing on the ridge. It was the same long range artists, so I ran across the open space and looked over into the next valley. The town was there, apparently deserted, and the barrage had stopped, but the machine guns and rifles were working across the ridge beyond the town and we could see the stragglers and wounded on that slope.

"I ran back to the trench with my pistol out and told the stragglers in the trench that if they did not pull those carts over the hill I would cut loose and hit a lot more of them than the long range machine guns. The carts went over the hill double time and our boys tagged along with their tongues out and just about all in. No one got hit and we slid down into the town in short order. No one there, but a red cross flag at a cellar door showed where the Germans had just vacated a dressing station. We went in and set up for business. The patients came in thick and fast as soon as the bearers got to the field and the reports got to the regiments.

"The Brigadier General and his staff came into town after we had filled all the shelters and had the patients stacked along the roadside. He was sort of surprised to find the lay-out there, as no other wheeled transportation, except the one-pounder cannons, had gotten through up to that time. After five hours the first medical officer of the other regiment got into town and brought no supplies except those in his belt and those of the few men with him. My supplies were not all gone, as I had been using those that Fritz had left, but then Bergeron

showed up with the first medical cart which he had brought through by buffaloing the M. Pr. at the first town and getting by the artillery and engineer trains. We turned the station over to the other officers, gave them a few supplies, and beat it over the next ridge and to the edge of the woods where our battalion aid stations had been established.

"We had an officer with a fractured thigh that Capt. Hurley and I had fixed up in a little shack, and the wagon was outside, when a rain of big shells came over and the driver deserted. We got our patient into the wagon all right and made the trip out and I drove the mules myself the rest of the afternoon and evening, riding the nigh mule, artillery style, and found I had not forgotten how I used to handle the 'wheel team, second caisson' in old Battery A. In that way we kept the battalion stations well supplied and brought the patients to our regimental hospital. There is not much professional highbrow work about my job, but the more soldiering I put into it the better the results."

"The Colonel saw me driving the mules and thought it a great joke, but he says we delivered the goods when the other Regimental Medical Detachments fell down, and I guess we did, because we treated as many patients of theirs as we did of our own regiment, and they treated only a few of ours. That seems sort of like boasting, but I want Andy to know that his father was not just a civilian dub, even if he was in the medical department."

On October 7th, as Major Webster was assisting a loaded ambulance from a mud hole, he was instantly killed by an exploding shell. He leaves to mourn his loss a wife and three small children (one of whom he has never seen), a father, mother and one brother, Capt. David Webster, of the aviation service.

Thus ends a very brief and inadequate sketch of the life of a man of the purest character and highest ideals. He will always live in my memory as a beloved friend, a skillful colleague, a true patriot, and above all, a man.

To the memory of the first Maine physician killed in active service in the great war, we add this second appreciation from the pen of our fellow member, Dr. Frank H. Jackson, of Houlton, Me.:

When a man goes out in a big way, helping others, the recognition of his sacrifice becomes all the more apparent. Without a doubt one of the main considerations of Dr. Webster was to do something for the other fellow. Whether that doing something would inconvenience him mattered nothing. He saw his duty to offer his services to his

country. To do so meant a great deal to him, for his home life and friends were his all. The empty life of society had no attractions for him, and with his powerful body behind a well-balanced mind he wanted to be in the midst of the big things, the things that men like to do, like the "good old Labrador days," as he has frequently said. In his home and with those who were fortunate to be numbered among his friends our colleague was at his best. The lovable nature of the man was then all the more evident, his natural tendency to a little shyness disappeared, and one soon learned to know the bigness of his mind.

To realize that such a friend is gone is hard. We must accept the sacrifice that he has made in the way that he would desire could he express his wishes. Working hard to rescue his ambulance from a bad hole, a direct shell-hit, sent on this fine fellow, this loving husband and devoted father, this fine friend whom we loved. The Maine Medical Association, his family, his friends, all of us have lost one of our best. We are proud to have known him.

CALCREOSE.

Calcreose is a creosote product, made in the United States of America, by an American manufacturer. Clinicians have used it with good results in the treatment of all forms of bronchitis, and especially the bronchitis accompanying pulmonary tuberculosis. It has been taken for long periods of time, and in large doses, without causing gastric irritation or discomfort; no burning; no nausea. Calcreose is also valuable in gastro-intestinal infections. Incidentally, the price of this product is far below that of other creosote products of foreign manufacture. The booklet, "Calcreose Therapeutics," which contains all information as to indications, dosage and method of administration, may be obtained by writing to The Maltbie Chemical Co., Newark, N. J.

Acne Vulgaris

SEVENTEEN cases of acne vulgaris were treated with yeast, and in every case the patient was improved or cured. Likewise, with acne rosacea, there was improvement or cure in all cases treated.

These results were observed in an investigation of the therapeutic value of compressed yeast, at Jefferson Medical College, the Philadelphia General Hospital, and the New York Roosevelt Hospital, under direction of Philip B. Hawk, Ph.D.

The conclusion of Dr. Hawk and associated physicians, as stated in their report, is that compressed yeast is fully as successful as any other remedy in acne vulgaris and acne rosacea! (Journal A. M. A. Vol. LXIX, No. 15.)

The dosage was usually a cake of yeast, three times a day, either before or after meals, administered in a suspension of water, fruit juices or milk.

FLEISCHMANN'S COMPRESSED YEAST is a scientifically cultured yeast, being of the species *Saccharomyces Cerevisiae*, and will be found to be of a uniform strength.

It is put up in the familiar tinfoil package and sold fresh at the grocery stores generally.

If FLEISCHMANN'S COMPRESSED YEAST is not on sale in the grocery stores in your city, write to The Fleischmann Company in the nearest large city and it will be mailed direct on the days wanted.

The importance of this investigation prompted us to prepare, in convenient filing form, a reprint of the report, with information on the production of the yeast. Copies have been distributed to physicians. If not received by you, please advise.

The Fleischmann Company, New York

Cincinnati, Ohio

Seattle, Wash.

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*Editorial Comment.***MILITARY OPHTHALMOLOGY.**

In a paper on "The Eyes in War," McKee mentions, in the *British Medical*, that the eyesight tests are not remarkably satisfactory, and that something more definite as to the wearing of lenses by soldiers ought to come up for international agreement after the war. He approves of spectacles which are of actual value to enable a soldier to see to shoot better, but does not believe in fitting lenses for infinitesimal degrees of astigmatism and oversightedness which are of no military value. He would have all cases of cross-eyes rejected, and objects to any operation upon them, because after the war such operations, even if done for mere cosmetic effect, enable shirkers to get an undeserved pension.

A good deal is said about night blindness, and mention is made of the fact that the Wasserman in iritis was positive in only 33 and negative in 72 out of 105 cases, which varies greatly from the figures in civil life. In his opinion there is nothing equal to mercurial inunction in syphilitic iritis.

Concussion of the eye from windage is mentioned and various internal injuries of the eyes collected and compared. A good deal of space is given, in conclusion, to repair of the face and orbits from military injuries, and various eye hospitals are mentioned and detailed for the study of those interested in the topic of military ophthalmology as a whole.

THE CHEMICOTHERAPEUTIC TREATMENT OF GONOR- RHOEA.

McDonagh, in the *British Medical Journal*, has called attention in various papers to the use of colloidal manganese in the treatment of gonorrhœa, and shown that it is most efficacious in the acute stages. But inasmuch as he observed that there is always some delay in obtaining the desired effect after injections of the manganese, he concluded to precede its use with a new metallic remedy made from palladium and known as pallamine. This should be injected intramuscularly, and two or three injections in all, at an interval of two days, employed.

Patients improve on a milk diet. If the acute case does not cure rapidly, then the colloidal manganese follows the pallamine every third day, and by injection, until the discharge ceases. McDonagh claims that a very few injections relieve acute cases of gonorrhœa with great rapidity and certainty.

Methylene blue is also employed, but after various trials the writer believes that preceding the manganese with pallamine, he can cure most acute cases inside of ten days, and annotates some fifty cases with good results. One of these cases relapsed, one developed epididymitis and two developed prostatitis.

THE ARMISTICE AND PHYSICIANS.

On the 11th of November of glorious memory, an armistice of thirty days was decreed between the allies and our enemy. With that impetuosity of nature characteristic of all Americans, our people and our physicians alike instantaneously imagined

Analysis Of Quaker Oats

Water	- - - -	7.7%
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Its cost is five cents per 1,000 calories. Meat, eggs, fish and fowl will average more than ten times that.

These are facts which women should know in these high-cost days. Ten people can breakfast on Quaker Oats at the cost of feeding one on meat.

Quaker Oats

This brand is flaked from queen oats only — just the big, rich, flavory grains. We get but ten pounds from a bushel.

This extra flavor without extra price has won millions to Quaker Oats.

The Quaker Oats Company
Chicago

(3008)

that the war was over; that nothing remained to be done by the people than to get to their ordinary work as of old, and for the soldiers to get a good character and certificate of good bodily health from their army surgeons, and to get homewards, to be followed at once by all of the surgeons. They were then to resume their daily routine of medical drudgery, to say nothing of working perhaps harder than ever to build up their practice depleted by their absence and decimated by the loss of families seceding to the care of physicians who remained at home during the war.

Much as we long to see a rapid end to actual war, and to the great work which our physicians have accomplished in so short a time, we must recall a few historical facts in order to abate the longings and the hopes of our fellow members who believe that there is nothing more to be done, that the war is over, and that they ought not to be kept chafing at authority in the camps. We have to remember, for instance, that between the declaration of the armistice between France and Germany in 1871, that peace was not declared for several months, and that German soldiers occupied French territory for more than two years afterward. France was at that time economically situated with gold, so that she was enabled to pay off in that short time the large indemnity demanded by Germany. In our days, Germany has no actual government, as yet, her credit is ruined, her manufactures largely stopped, so that there can be no doubt of the need of occupation of parts of her territory for five years at least. Five years of occupation, and largely by American soldiers, because they are the most acceptable to the Germans, means five years' medical care of our soldiers by our physicians. If the surgeons of the regular army are unable to care for the million of men needed for an occupational army, then surgeons will be obliged to remain abroad just so long as the soldiers remain.

Let us hope that the time of occupation may be shortened, but let us not forget to remind our gallant associates that there will be much for them to do on both sides of the ocean for a long time to come yet. Whether the government will send back all of the surgeons who have been seasoned "over there" and send out new men in their places is not yet determined. We have no doubt, however, that those who are there are largely satisfied with their work, and that they will gladly obey their orders for a long period of time. As for those on this side, some will be very sorry to come back to work with never a sign or a token of service abroad. Many of them we believe would be glad, even at this late day, for orders overseas.

OUR VOLUNTEER MEDICAL SERVICE CORPS.

Records at Washington now show sixty thousand enrollments of physicians with complete code cards ready for further work. Some eleven thousand physicians are enrolled in class 1, under 55 years of age without physical disability and with no or but one dependent; ten thousand come in under class 2, being under 55 without physical disqualifications but with three dependents; ten thousand in class 3, under 55 without physical disqualifications but with more than three dependents. Class 4 contains nineteen thousand members, either over 55 or under, with disqualifying physical disabilities, or already so disqualified, or registered as women physicians. Classes 5, 6, 7 and 8 contain exceptional instances of physicians ineligible for various causes, and waivers.

A medical grouping of all these physicians show 49,200 general practitioners, including members doing some surgery or having hospital appointments, and are internists, pulmonary experts or pediatricians. Then comes the surgical group of surgeons exclusively, surgeons who practice medicine also, those with hospital appointments, various special surgeons for regional surgery, bladder, mouth, abdomen, railway, and finally anæsthetists.

Next we have the eye, ear, nose, and throat specialists enrolled with neurologists and psychiatrists, and finally the laboratory group, including pathologists, bacteriologists, microscopists, chemists, hygienists and radiologists.

Under the next classification we find preference for service of 30,000 for the M. C. of the Army, 4,000 for



We Hide Bran In Wheat Flakes

In a delightful dish which, for 20 years, has been a favorite breakfast dainty.

There is 25 per cent bran, and the bran is in flake form to be extra-efficient. Yet it is inconspicuous.

It was made to please doctors who wanted a bran food which people will continue. And thousands of doctors advise it.

People who need bran will gladly eat Pettijohn's, and start every day of the year on it. But they soon quit clear bran, as you know.

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Rolled Wheat—25% Bran

A breakfast dainty whose flavory flakes hide 25 per cent of bran.

Also Pettijohn's Flour—75 per cent fine Government Standard flour, 25 per cent bran. Use like Graham flour in any recipe.

(3064)

the M. C. of the Navy, 15,000 for the P. H. S., and the remainder, so far as expressing any preference, wished to go generally on advisory boards.

In the section devoted to industrial service we note that more than 45,000 have never been so employed, that some 11,000 have done surgical or medical and surgical duty in industries, and that no less than 1,725 are at present on contract practice.

Classified as to ability to utilize languages, over 50,000 speak only English, 1,155 speak French and English, 4,125 speak German and English, 1,659 speak French, German and English, and so on, including Spanish, Italian, Russian, Norwegian, Yiddish, and other dialects.

In conclusion, it is plain that the determined effort to obtain enrollment of all physicians of the nation into either active or volunteer service has resulted in obtaining information concerning the profession as a whole, which will be invaluable, and should, once begun, be continued so long as the nation lasts. It is interesting to note, that we have so far obtained accurate records of the age and average ability of over 110,000 of the estimated 130,000 medical practitioners in America, and it is hoped that the good work will go on until all are enrolled for future emergencies.

County News and Notes.

CUMBERLAND COUNTY MEDICAL SOCIETY.

The annual meeting of the Cumberland County Society was held at the Congress Square Hotel on the evening of Friday, December 13. The business part of the meeting, including the election of officers for the ensuing year, was indefinitely postponed, owing to the inability of many members to be present from bad weather, and absence in the medical service of the nation.

James A. Bagley, Secretary of the State Board of Charities and Corrections, read a paper on "State Appropriations for Hospital Treatment of the Poor," and Lieut. H. E. Hitchcock, of the United States Public Health Service, gave a valuable talk on venereal disease control. The JOURNAL expects to print both of these papers in due season.



New-Type Gelatine Foods

For the Sick and Convalescent



Loganberry

The favorite berry flavor



Pineapple

We use a whole pineapple to flavor one hospital-size package.



In Glass Vials

All flavors come in liquid form, in glass.

Gelatine foods have attained new recognition among medical men since the advent of Jiffy-Jell.

It employs a rare-grade gelatine. All its fruit flavors are made from fruit. They are highly condensed and abundant. And they come in sealed glass vials—a bottle in each package—so the fresh-fruit flavor keeps.

No Sugar Restrictions

The U. S. Food Administration placed gelatine preparations for hospital use in the essential class for sugar allotment, because of their importance in the dietary of the sick and convalescent.

The U. S. Army Camp Hospitals use Jiffy-Jell in a large way. And our Waukesha Gelatine, the basis of Jiffy-Jell, has been ordered by the Government for overseas shipment in million-package lots.

A Food and a Food Conveyor

Jiffy-Jell forms an easily digested food. Its wealth of fruit flavor makes it appetizing. It comes ready-sweetened, with the flavor in a vial. One simply adds boiling water. Other desirable foods can be made inviting by mixing them in the Jiffy-Jell before it fully cools.

The home size makes a pint of jelly—the hospital size makes a quart. Both come in ten flavors, all sealed in glass.

All grocers sell the home size—all jobbers sell the hospital size. But be sure to get Jiffy-Jell, the only gelatine dainty with the true fruit flavors in bottles.

Jiffy-Jell

Home Size and Hospital Size—True Fruit Flavors in Vials

Ten Flavors—In Glass Vials—One in Each Package

Mint	Lime	Raspberry	Cherry	Loganberry
Strawberry	Pineapple	Orange	Lemon	Also Coffee Flavor

Waukesha Pure Food Co.,

Waukesha, Wis.

Correspondence.

EUGENICS—"CALL A SPADE A SPADE."

Mr. Editor:—Will you be so kind as to give space to this brief letter upon a subject of importance to every community in our State?

When we consider the far-reaching effects of venereal diseases, and especially the one which by your leave I propose to discuss, syphilis, it seems strange that no systematic effort has been made to stay its course. If this disease affected alone the man who contracted it, if the man or woman was the only sufferer, then we might hesitate to "call a spade a spade" and leave the matter to him and his physician, but in the large percentage of cases this is not so. "The sins of the fathers are visited unto the children of the third and fourth generation," never rang more certainly the truth than here. It reaches its tentacles of disease and death into the innocent unborn children; its slimy grip often holds its hand until youth is reached or is passed, then health fails, the firm step falters, the bloom of youth fades. Most hardened brain cells, the locomotor alaxys, the losses of sight from chronic disease, are due to this death-dealing virus, and often, so often, the author of it all lived generations back; and yet with this knowledge, known to all men, the public laws have excused the author of all these woes from having his disease, the most virulent, among the most contagious, recorded with the name of the carrier. Why?

Every physician and most intelligent men know the evil of marriage, the horrible results too often following even when the symptoms have disappeared. What right has any man, by all the laws of right and God, to send into unborn generations this virus of sin and destruction? Why should he be allowed to do it by the laws of our State, or the lack of them?

Every infectious disease, except venereal, is now reported and recorded by name and disease. Syphilis, among the gravest dangers to the human race, should be reported and recorded in exactly the same way and every unmarried syphilitic should be prevented by law from marriage, unless pronounced cured by a proper board. If not why not?

Sincerely I hope the legislature of Maine and the people of the State, in the coming winter, will rise to the occasion.

Geo. W. PHILLIPS.

Bar Harbor, Me.

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For Injuries to the Skin

While it is more generally used in the treatment of burns, it also is employed successfully in the treatment of all injuries to the skin, where, from whatever cause an area has been denuded—or where skin is tender and inflamed—varicose ulcers, granulating wounds of the skin, etc.

Surgeons will find it useful to seal wounds after operations instead of collodion dressings.

It maintains the uniform temperature necessary to promote rapid cell growth.

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Vastly superior in color to any other petrolatum heretofore offered.

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PERSONAL NEWS AND NOTES.

To the list of Maine physicians who have lost their lives from medical service to the nation, we regret to add that of Dr. Carl D. Gray, who died suddenly, December 19, on his way home, after an honorable discharge from active service.

Dr. F. E. Wheat, of Rumford, who has recently received his honorable discharge from the army, has located in Westbrook.

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Only the best of material is used and we never substitute.

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are the finest thing of the kind on the market; they are strong, smooth and sterile. Plain and 10, 20, 30 and 40 day Chromic, sizes Nos. 000 to 4, inclusive. At present, 60 inch lengths only.

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CHICAGO

Maine Medical Association meets at Portland, June, 1919

THE JOURNAL

OF



THE

Maine Medical Association.

The Official Organ of the State and County Medical Societies.

VOL. IX, No. 7

FEBRUARY, 1919.

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It has been thus extensively resorted to because of its long proven
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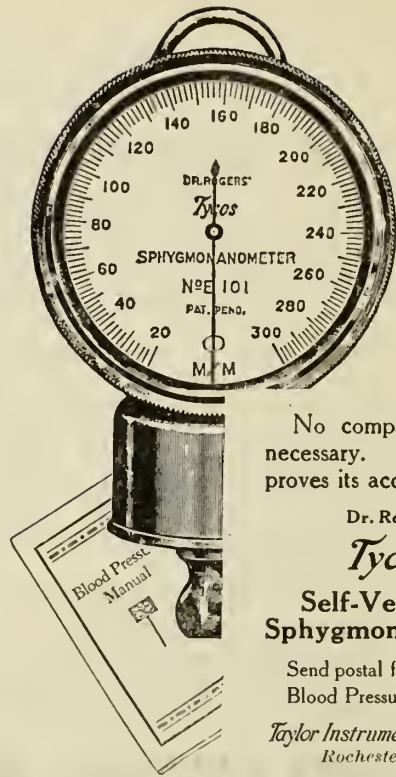
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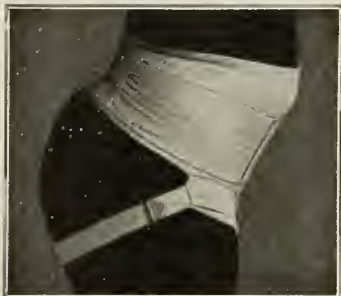
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* A NEGLECTED MEANS OF DIAGNOSIS IN CIRCULATORY DISEASES.

By S. J. BEACH, M. D., Augusta.

Cardio vascular diseases can, for the purposes of this paper, be discussed as a group. The ocular manifestations, which are those to be considered, have certain characteristics common to the entire class, and it is these only that are to be mentioned. The most frequent of these diseases is arteriosclerosis, and it may fairly be taken as the type. It is so common that it is almost regarded as a physiological process, to be classed with such signs of maturity as a bald spot and store teeth—something that comes to all if they live long enough, and when it comes must be made the best of.

Advances in pathology have not been encouraging. Thoma demonstrated in arteriosclerosis a change in the inner coats of the blood vessel walls to fibrous tissue. Such a tissue change comes usually as a measure of repair. From this analogy Thoma concluded that the process here is an effort to strengthen walls of weak blood vessels against dilatation from increased resistance in the peripheral circulation. This increase is attributed to a multitude of intoxications and strains. Someone has observed that nature has chosen an imperfect method of adaptation in this case. Degeneration of the new tissue leaves the condition worse than before.

For hard, fibrous tissue, once formed, we have no reliable remedy. Prevention then is the only weapon. If the cause of the process is high peripheral resistance, this must be lowered before the walls are

*Read before the Maine Medical Association, June, 1918.

damaged. Off hand this proposition sounds a good deal like stopping the German drive. To quote Forcheimer, "It is rarely possible to do anything to prevent the development of this disease * * * We cannot prevent the first stage, because patients seldom present themselves to us. When they do, much good can be done."

Now, I may be sadly in error, but it is my firm belief that we are constantly visited by patients in the first stage, and don't recognize it. How can we? Would you risk a diagnosis of the presclerotic stage on a slightly subnormal blood pressure or soft heart sounds, due to lax vessels, or to slight alteration of the proportions of the urine, or general lack of "pep"? In fact, would all these symptoms together establish the diagnosis? Then there is left but one resort. Take an ophthalmoscope and look at the blood vessels. Not all cases will show it, but an astonishing proportion will.

Marcus Gunn is credited with first calling attention to circulatory changes in the fundus in 1892. Ten years ago Stengel, in an excellent article, stated that in the eye vascular changes are displayed with a clearness and minuteness nowhere else obtainable in the living body. He might truthfully have said that the eye is the only place in the living body where they are displayed at all. In the Ophthalmic Year Book for 1915, Jackson reviews his own papers on the subject and suggests that every patient suffering from angiosclerosis be submitted to an ophthalmoscopic examination. This idea might properly be expanded to cover all circulatory diseases. It is common knowledge that the fundus frequently reveals the condition of the kidneys often before the urine does. Both these organs have a terminal circulation, that is, without collateral vessels. Possibly this is a reason why they suffer alike and at the same time. The retinal vessels further seem frequently to offer evidence regarding the condition of the adjacent cerebral vessels. It almost seems that every patient on whom a routine physical examination is done could profitably be ophthalmoscoped. This could hardly be done in every case by an oculist. Is it worth the general practitioner's while to undertake it?

First, how much does it involve? It is safe to say that no one is graduated from a first-class medical school to-day without being obliged to make some shift at using an ophthalmoscope. The rudiments of the practice are really not as difficult as the technique of a physical examination, and in the average case take less time. This is particularly true of the electric instruments. For the purposes of this paper, only a few simple and readily recognized signs are to be regarded, which can be noted by anyone who can tell a straight line from a curve. They concern entirely the retinal vessels, as it would be worse than a

waste of time for the average man to bother with anything else. Fundus changes, as a whole, are recognized with difficulty after years of constant application.

You will note that the blood vessels of a normal retina taper and divide uniformly towards the periphery of the fundus with a gentle undulation not unlike the branching of a tree. The veins are slightly broader and darker than the arteries. The nerve head in color contrasts sharply with the retina. Down the center runs the light reflex, bordered on either side by the darker color of the blood stream. Now any deviation from this picture should make the doctor take notice. It is guilty till proved innocent.

An early change is increased sinuosity of the arteries. Beard says the smaller vessels are obviously more susceptible of tortuosity than the larger ones and speaks of the distortion as "corkscrew," or "yarn ravelling." The larger arteries may become engorged, and wider like the veins, and tapering less regularly. Before systemic sclerosis sets in, the fundus may show an advanced stage. The twisting and engorgement is then taken on by the veins, while the arteries narrow and straighten. In fact, to the hasty glance they look more normal than before. As the arteries harden they dent the veins they cross. Finally, they shrink in parts and the lumen obliterates. Other portions dilate and even rupture, with small hemorrhages. There is one point to remember. Genuine pathological changes are not uniformly advanced in all parts of the retina. Rarely congenital abnormalities resemble the early stages of disease except that the fundus appears everywhere alike. As Fuchs says, "Dilatation and tortuosity of the retinal vessels can be regarded as pathological if unilateral or confined to certain districts of the fundus."

A few actual cases are more convincing than these theories. The patient that first made me feel the need of really seeing the vessels was an overworked lawyer. He called me to his bedside under the impression that an attack of vertigo was due to his eyes. Every time he got up the room lurched. His refraction was all right, but his fundus was a wonderful clinic in hardening of the arteries. He took some of my advice—enough to get straightened out by his family doctor—after which he went back to his office and died in two years of apoplexy. If his physician had seen that fundus he would never have let the man go to work after a temporary remission.

This winter a young woman, seven months pregnant, consulted me about a fog before her eyes. The urine a week before had showed no albumen, although the left eye had then been blurry a week. Now it was very bothersome, and the right had begun to dim. It showed

pronounced albuminuric retinitis. That a like appearance showed in the left eye the previous week is my belief, at the time when the urine was negative, but the vision blurry. It was now showing general œdema and exudate in the retina. On my recommendation, she was sent at once to the hospital. Her urine showed albumen. In spite of heroic treatment she promptly developed eclampsia and was delivered. The baby was lost. Her left eye has never fully recovered. Now, if she had any show to save her baby and her eye it was when she showed no albumen, but was getting a mist before her left eye, and almost certainly had changes in her fundus.

Less dramatic, but happier than these, was a patient referred by a colleague in a neighboring town, a young woman who was physically subnormal. Her physician suspected her circulation and inquired about her fundus. There the clue was given by the yarn ravelling appearance of the superior temporal artery system in the left eye. He put her on treatment, and reported surprising benefit.

These are samples that occur to me out of groups and series with a strong family resemblance. They are common to the practice of all oculists. You have all, I venture to say, had more than one such surprising report from your consultants. Furthermore, none of these cases required any special diagnostic skill. Only the last, where the small area needed some search, took as long as a sphygmomanometer examination.

It is my feeling that if, without spending any great amount of time, the general practitioner would familiarize himself with the appearances of the retinal vessels and note their gross deviations, much suffering would be prevented. Plenty of clinical material is present in every man's practice. Today the oculist sees the blood vessel. The man who treats blood vessel disease never sees it.

Without actual experience no physician can possibly realize the value of fundus evidences in general practice. We have a quarrel, I feel, with the courses of required ophthalmology in our Medical Schools for not placing more stress on the retinal circulation, which is so important, even if they have to displace some problems like the diagnosis of glaucoma, which puzzles even skilled specialists. We would then have the younger profession understanding a large field of diagnosis, which, in the stress of busy practice later, they will without such foundation be reluctant to enter.

If, however, my colleagues are not convinced that they can profitably use the ophthalmoscope, this paper will still have served a purpose if it has shown the worth of a fundus examination by a specialist in cases more especially of pregnancy and nephritis, which may other-

wise suffer a calamity. The oculist will, of course, find other signs than the simple ones I have mentioned, and his observations may give the clue to prevent chronic invalidism or even death.

In conclusion, it should be emphasized again that not all cases of circulatory disease show changes in the eye. Where such a high proportion does, this does not detract from the importance of routine fundus examinations. The practitioner should be again warned not to waste his time on general considerations, but should apply his attention solely to the retinal vessels. Changes in these are apt to show early. They are usually most marked in some one group of vessels, and are characterized by easily recognized alterations in the contour and outline of the vessels.

PRESIDENT SPALDING: I note with pleasure that Dr. Hardy, of Waterville, is to open the discussion of this paper by Dr. Beach, and we shall be very glad to hear from him his opinion in regard to the ophthalmoscope as a means of diagnosis in circulatory diseases.

DR. HARDY: Mr. President and Gentlemen: I hardly know why Dr. Beach asked me to open this discussion, unless perhaps because I have made such an absolute fizzle in using the ophthalmoscope. I have been endeavoring for some little time now to acquire skill in using the ophthalmoscope, and intend, and in fact, do use it, as a routine method in all examinations, but thus far I have been unable to see any beautifully colored pictures such as he has displayed here. I hope to some day. I think the important point brought out by Dr. Beach is that by the means of the ophthalmoscope you can discover cardiac diseases, vascular diseases, earlier than we are able to by the older clinical methods. We all realize the fact that usually when these conditions are discovered by the older clinical methods our remedial measures are very much limited. A man so afflicted, if he limits himself to the condition of his kidneys or of the circulation, may get on for some years very nicely; but he is a very much handicapped man. If this means that Dr. Beach has pointed out would give us a method of discovering these lesions earlier, when they would be more amenable to treatment, I think it would be of great value to the general practitioner.

DR. WARREN: Mr. President, the Association is honored this afternoon by the presence of one of the most distinguished obstetricians and gynecologists of America, Dr. Dickinson, to whom this whole subject of albuminary retinitis is an old story. I am sure the courtesies of the Association in debate would be very gladly granted to him, and I am also sure I should like to hear from him.

DR. DICKINSON: Mr. President, I agree entirely with the speaker, that if I were to begin over again I would not think of practicing obstetrics without knowing something about the fundus of the eye, and some of the disasters which strike out of apparently clear skies could unquestionably be detected with the ophthalmoscope. It is but one more of those strong arguments for root diagnosis which are so common nowadays. With men in some of the scattered localities, the only thing for a man to do is to constitute himself a team and be able to do some of the commonplaces of diagnosis. Students are now being taught to recognize early these grosser changes in the eye as part of their work

in the routine tests. We even have been able to teach some of our very intelligent pre-natal workers—and you know how women often are in these finer things, and you find a type of women now coming into some of that kind of work,—not the old midwife type, but women who see the need of doing something. You can start some of your neighbors on this pre-natal study if you haven't time to do it yourself.

DR. SPALDING: I would be very glad to say a few words myself on this topic. The greatest trouble with the ophthalmoscope is that most men who are not specialists in diseases of the eye take it up and try to find out what they are looking at. Now, if those who are interested in the study of the ophthalmoscope as general practitioners would take ordinary healthy eyes that come to them right along, children in their own families and patients with enlarged pupils, they would not have much difficulty in learning what a normal fundus of an eye looked like. If they learned once with the electric ophthalmoscope, or any other kind of an ophthalmoscope, what the normal conditions were, they would soon recognize those that were abnormal, and that is a little different, but not very much. It is not a very difficult study. The main trouble is that they do not make the room dark enough, and they get reflections from the curtains and windows. I have always been pleased to teach the physician in regard to the use of the ophthalmoscope, but it is one of those things that is best learned by looking into the eyes of children or young people who have enlarged pupils. The smaller the pupil the more difficult the examination is. It is most curious to think that inside of the eye we can see so many diseases. For instance, we can tell lead poisoning. We know the condition of the eye shows diseases of the retina. From certain inflammation of the optic nerve we can tell that a person has a brain tumor. We know about nephritis and we know about the circulatory diseases to a certain extent. Now, I will tell you a case that I saw a few days ago. An old man of 75 was sent to me with loss of sight in his left eye; it had gone completely. His consulting physician thought that he might have a glaucoma or that he might have had a cataract which had developed with great rapidity. It took me about two minutes to look into the interior of the eye and see that the fundus of the eye was not obstructed by anything in the way of a growth, and I could tell very soon that he had an embolus of the central artery of the retina. I said to him, "You must have some trouble with your circulation." He said, "My doctor has been treating me for heart disease for two or three years." "Well," said I, "that accounts for it. You have had a small blood clot start off from your heart, and it has gone into the eye, and it has blocked up one of the arteries of the eye, and I am sorry to say that your chances of ever seeing again with that eye are very poor." Now, there was the diagnosis made and I knew nothing of the man's condition. I knew that he had a heart disease, and that he was blind from an embolus formed in the central retinal artery. There are a good many people who have arteriosclerosis and who have retinal hemorrhages, generally in one eye, I am glad to say, although sometimes they occur in both. The question that interests me is this: Shall the eye doctor treat such cases as well as he can, or shall he leave them to the general practitioner? If the eye doctor treats the patient, he hardly knows exactly what to do when he sees what is going on, and if the general practitioner sees what is going on, all that he can do is to give remedies that seem to him best to reduce the arteriosclerosis. Therefore, I say that in all cases where a patient is reported or believed to have loss of sight from a blood clot formed in the retina,

due to any cause whatsoever, that there should be frequent interchanges of opinion between the consulting physician and the oculist, so that one may look in the eye and see what is going on and the other examine the heart and tell what is proper to be done. Of course, the best way would be for the general practitioner to master the ophthalmoscope, but until he does I think that such cases as these ought to be treated by the two men combined, and the general practitioner should attend the case, but say to the patient, "I cannot see what is going on in your eye. I want you to go to your eye doctor and report to me once in three or four weeks, so that I may see the condition of the blood clot and see that you are doing as well as you can."

I agree with Dr. Beach that the ophthalmoscope is a neglected means of diagnosis of circulatory diseases, and I shall be glad when every physician understands something of its use; and I will say that, although the cost of an electric ophthalmoscope is considerable to start with, yet it is always ready. You can use it at the bedside and it is invaluable as a means of diagnosis. (Applause.)

***STATE APPROPRIATIONS FOR HOSPITAL TREATMENT FOR THE POOR.**

By JAMES F. BAGLEY, Secretary State Board of Charities, Augusta.

Gentlemen:—I am very glad indeed to have this opportunity of speaking to you upon this subject of "State Appropriations for Hospital Treatment for the Poor." I believe that, with the possible exception of the patients in the hospitals, there is, or ought to be, no group of our citizens who are more interested and more anxious to have exact knowledge upon this subject than the physicians and surgeons who are giving so freely of their time and strength, their knowledge and skill, "without hope of fee or reward," to benefit their unfortunate fellowmen.

Before taking up specifically the subject assigned to me, I wish to outline, briefly as I may, the general situation with regard to public appropriations of all kinds for the care of the dependent classes of our population, more particularly with reference to their care by private institutions. I use the term private to apply to institutions which, while they perform a more or less public service, for instance, the preservation or restoration of the public health, are nevertheless not in any way under the direct control of the public, are not owned or controlled by the State or by any political subdivisions thereof.

* Read before Cumberland County Medical Society, December, 1918.

There are practically only three sources from which the money can be obtained to provide for the State's large army of dependents, for whose care and treatment some arrangement must be made—the insane, the feeble-minded, those in penal institutions and reformatories, the tuberculous, the sick, paupers, etc.

First: The State itself.

Second: The various cities, towns and counties, which for all practical purposes may be considered together; and

Third: Private benevolence.

The question as to how the expense of caring for the dependents above mentioned shall be divided among these three possible sources of income is largely one of expediency. It is commonly agreed that the insane, the feeble-minded, prisoners (to a certain extent), the blind, and in later years, the tuberculous, are in a peculiar sense wards of the State, for these reasons:

First: In most communities the State has seen fit to assume the care of these particular classes, so that the people at large have come to expect the State to care for them, with the result that if the State for any reason failed to provide for these unfortunates there might be serious difficulty in arousing the private citizenship to make any substantial contribution toward their maintenance and support.

Second: The insane, the feeble-minded and prisoners require for their proper handling the exercise of what, to all intents and purposes, is the police power of the State. They have to be cared for, not only for their own protection but for the protection of society at large. The argument of protection applies equally to the care of tuberculosis. Perhaps none of these arguments are conclusive, but they are generally accepted and the State has entered upon the policy of caring for these classes. Therefore the State should see to it that those charities and corrections which the State has undertaken to finance wholly from the public treasury should be properly financed. How much money the State can afford to spend for the institutions caring for these persons is a matter for the people to determine through their chosen representatives in the legislature. Clearly, these institutions should be properly provided for *first*, and the legislature should continue the policy which it has pursued during the last eight or ten years, namely, not to make any appropriations for the construction of buildings which are not the property of and wholly controlled by the State.

PAYMENTS TO INSTITUTIONS NOT OWNED OR CONTROLLED BY THE STATE.

In Maine the political unit which is required by law to assume the burden of caring for such socially inadequate persons as the aged and infirm, the sick, and orphaned and friendless children, is the town. Private benevolence, however, assists largely in the care of these persons, and Maine, unlike most other States, adopted the policy of making appropriations in aid of private institutions caring for these persons whom the cities and towns are legally bound to care for when they fall into distress. It has been one of the only three States in the Union making liberal appropriations, with slight differentiation between State and municipal, or private responsibility, to comparatively large numbers of institutions, with little regard to the needs of the locality served or the resources of the community. Prior to the establishment of a State Board of Charities and Corrections, this State stood alone in its absolute lack of any supervisory authority over the organizations assisted.

Until recent years it has made liberal appropriations toward the construction of buildings which the State did not own and upon which it had no legal claim when they were completed. Before the State Board of Charity began work there was no successful attempt to check up the application of the appropriations to the purpose for which they were made or to determine carefully whether or not the appropriations were actually needed at all. The only requirement to secure the money was friends among the Legislature to speak in behalf of the institution. No intelligent comparison could be made of the relative merits of various institutions or the relative needs of the various sections of the State.

I do not wish to repeat or enlarge upon the arguments for and against such a system, its uses and abuses, its advantages and disadvantages. The policy cannot now be wholly changed, although its disadvantages are, under recent legislation, being minimized. The important question to be determined is how far the State wishes to go in the care of sick persons, who, though they may be entitled to pauper supplies, have not yet been reduced to the necessity of applying for them; similarly, how far the State desires to go in the care of dependent children. Shall the State assume all of these burdens? No other State and no other country does. And the question might well be asked if the State takes care of the indigent sick, why not also care for other indigent persons who for any reason are unable to be self-supporting?

It is agreed by experts who have made a study of the best methods of caring for those socially inadequate classes not included in the list

given above as generally cared for by the State, that the political unit which bears the burden should be no larger than is necessary to admit of economical administration and experienced service; that it should be only large enough to contain a sufficient population so that an institution of proper type, properly equipped, can be maintained. In pursuance of this policy, the State Board of Charity has recommended to the Legislature that while the town should still continue to be the unit which furnishes relief to poor persons in their homes, it will be necessary to create larger districts in order to maintain institutions for those requiring that kind of care, such institutions to be known as district homes and infirmaries. Thus far the State has not undertaken to assume the entire cost of the free treatment and care given by private institutions. I do not believe that it should undertake to do so. Local communities should contribute, either through municipal funds or through private benevolence, toward the care of their dependents. If they do not, careful inquiry will not be made into the needs or abilities of the person seeking the care. Dependency will be encouraged. The aid which the State gives will degenerate into a log-rolling scramble to see which section of the State, or for that matter, which community, which institution, shall secure the largest appropriation. That condition has been perilously near to us in the not distant past. The State has appropriated during the last few years for the care of children, for the treatment of the sick, for the education of the adult blind, between 50 and 60 per cent. of the average net cost of maintaining the institutions in which those persons are being cared for. The recommendations of the State Board of Charity for appropriations for those institutions are based upon that general division of the cost between the State and the local community.

CONDITIONS GOVERNING PAYMENTS TO INSTITUTIONS NOT OWNED OR CONTROLLED BY THE STATE.

When the State makes any appropriations for the care in State institutions of persons who are unable to care for themselves or from whom society must be protected, it says to what persons and under what circumstances care should be given. It should do the same in other institutions. While the Legislature determines the maximum amount appropriated, such appropriations should be paid only when properly itemized bills, showing not only the date upon which the service was rendered, but the nature of the service, who rendered it, and at what price, further, that the price charged was no greater than that charged to the general public for the same service, have been audited by the State Auditor.

That in principle, at least, this was the belief of the Legislature of 1913, is evident from the provisions of Chapter 166 of the Public Laws of that session, which stated that the prices charged by any institution receiving State appropriations for hospital service rendered to those able to pay for it should not be less than the average per capita cost. This law, however, did not accomplish the purpose for which it was intended, for the reason that it is impracticable properly to enforce it. The character and cost of the various kinds of medical and surgical service vary greatly. To require that all persons shall pay not less than the average cost of all service when they actually need a service that costs much less than the average, or to ask that as an act of charity they be given a special discount, is manifestly unjust.

On the other hand, while hospitals may determine accurately the average cost of all service, none of them in this State is able at best to more than estimate the relative costs of ward care, private room care, etc. Furthermore, it has for a long time been recognized as a sound premise in the social and civic betterment of the human race, that hospitals conducted as are most of those which are receiving State aid, not as a profit-making enterprise but as a charitable social agency, may well endeavor to make a profit from the more elaborate and expensive kinds of care dispensed to the well-to-do, which is to be used in reducing the cost of such service as is actually necessary to those less fortunate. Furthermore, under the plan of making a lump sum appropriation to an institution and then paying it over to the institution in two semi-annual payments without any itemized bill, which plan was in effect up to two years ago, several institutions received money which they did not require.

Again, we would not offer to pay a man a certain price for paving a given area of street, and permit him to select the street, without regard to the need of that particular section to be paved. The same principle may well apply to the expenditure of the State's money for charity. No one will question the premise that an institution should not be paid for more free service than it gives to the public. It is equally clear that free service should not be given where it is not required, and to base the amount of the appropriation solely upon the amount of free service rendered, without regard to actual need for such free service, is to discourage a proper investigation of the ability of the person receiving care to pay for it. It is right, also, if the money of the tax payer is to pay for the service, that the necessity for it should be passed upon, or at least reviewed, not by the corporation or individual that is to render the service and be paid therefor, but by some public official representing the tax payer.

Previous to 1917 the appropriations which the State made for the care of persons in general hospitals, children's institutions, etc., were made in a lump sum, payable to the institution, to do practically what the management liked with it, to exercise their own judgment without let or hindrance as to what persons should receive the benefit. The Legislature of 1917 made a marked departure in the procedure with reference to appropriations for the care of children, for treatment of poor persons in general hospitals, etc. It enacted a law requiring that such appropriations should only be paid when duly itemized bills, showing the name of the person cared for, the period of care, the rate per week, etc., and bearing a certificate of the State Board of Charities and Corrections that satisfactory evidence had been filed in its office that the persons cared for were actually unable to pay for their care or treatment had been passed upon by the State Auditor. This law has made a lot of work for the State Board, but I assure you, gentlemen, the work has been well worth while. Standards of investigation have been developed. Those with low standards are gradually learning that when a man asks you to take care of his children for him, or to provide free medical treatment for himself or for his wife or his children, you have a right to know how much he is earning and how many persons are dependent on him for their support. Many thousands of dollars which would otherwise have gone in payment for the care of those who were able to care for themselves, have been saved to use, and have been used, in payment for care for those who actually needed assistance.

So much for the general principles involved. Just at this point you will be interested to know what rules the Board found it necessary to adopt in order to apply this statute practically. Let me quote from a general circular sent to all hospitals concerned:

Suggestions for determining questions arising under Section 3, Chapter 114, P. L. 1917.

1. Does the patient require medical or surgical treatment? The Board must perforce accept the opinion and action of the medical or surgical staff of the hospital as *prima facie* evidence upon this point.

2. Does he require use of operating room, X-ray treatments, special serums, etc. If these items are billed it will naturally be assumed that they were required and given upon orders of the attending physician. Such items should, however, be entered on the bill as special items, each item on a line by itself.

3. Shall ward or room rates be charged? It is expected that State account patients will be cared for in wards at ward rates, but if

the nature of the patient's illness is such that a private or semi-private room is prescribed by the attending physician as necessary for the proper treatment of the case, the regular rate charged by the hospital for the lowest priced suitable room will be allowed. In such cases a notation to that effect should be made, either on the bill itself, or on the accompanying evidence of the patient's financial status (Form 70). Private or semi-private rooms furnished for the convenience of the hospital, that is, because no ward beds are available, or because the physician or patient thinks the room is pleasanter than a ward, can be allowed only at ward rates.

4. Number of persons dependent on the head of family, average weekly income, amount of assistance received from town, etc.? In most instances all of the facts cannot be obtained before or at the time of the patient's admission, but the case should be followed up, the data obtained and its correctness vouched for by one or more disinterested persons before a charge is made against the State appropriation. The attending physician must usually be regarded as a party in interest seeking the best he can obtain for his patient, and the endorsement of other persons should be sought upon the question of financial condition of the patient or his responsible relatives. When the income stops with the admission of the patient to the hospital it will be well to note that fact on the card (Form 70).

5. Families who are receiving or have recently received assistance from the town? The State appropriation was made for the purpose of providing hospital treatment for poor persons who would not be a charge upon the public treasury except for their need of hospital treatment. When members of families who are found to be receiving assistance from the overseers of the poor, require hospital care, their needs should be promptly reported to the overseers of the poor of the responsible town. If they decline to become responsible for the payment for care or make other suitable arrangements for the patient, it would be well to report the case at once to the State Board for instruction before actually billing against the State appropriation.

6. Bills unpaid by family willing to try to pay if given time? Do not bill these cases against the State appropriation until at least 90 days after care was rendered. While it is the desire of the State to pay all its bills within the calendar year, unexpended balances remaining at the end of the year will be available for payments in cases of this kind until June 30 following.

7. Persons promising to pay but in the opinion of the hospital authorities unable to do so? Such bills may properly be charged

against the State appropriation if accompanied by memorandum to that effect.

8. Workmen's compensation cases? Hold for decision by Industrial Accident Commission, then balance of the bill, if workman is unable to pay it himself, and the insurance company or employe is not liable, may be billed against the State.

9. This office will be glad to answer questions at any time. Construe questions of ability to pay liberally in favor of the man or woman who is honest and industrious; strictly against those who are seeking to obtain something free because the State or endowed bed funds pay for it.

I wonder if just about this time you are not beginning to ask, in your minds at least, how much money does the State spend for the care of poor persons in hospitals, exclusive of those for the insane. In 1917 and 1918 the appropriations for the care of poor persons in hospitals not owned or controlled by the State amounted to \$90,900.00. This was apportioned among twenty-four hospitals. The largest amount to any single institution was \$27,500. The smallest amount was \$500. In one case the appropriation did not go to the hospital, but to a ladies' aid association, which, in turn, paid the money over to the hospital, a hospital which even questioned the right of the State to follow its money to the hospital and see that it was properly expended, or that the patients for whose care the State was paying were in an institution which maintained proper standards. One hospital declined to accept any of the appropriation which was made to be expended there. Mind you, the appropriations are not made to be apportioned by any State executive body as the needs of the community and the exigencies of the situation during the two-year period may indicate as necessary and just, but so much may be earned by each hospital. Six hospitals did not render sufficient charity services, where the need met the State standards, to earn, and so did not receive, their entire appropriation. Unfortunately, under the terms of the law the unexpended balances could not be expended in other hospitals, where it was sadly needed, but lapsed to the State contingent fund.

For 1919 and 1920, requests filed with the State Auditor and reviewed by the State Board will amount to \$127,000 each year, divided among twenty-two hospitals, three having dropped out and one new one having come in. The division of 50 per cent. of the net operating cost paid by the State, and fifty per cent. by the local community, either as income from trust funds and endowments, gifts, or payments by cities and towns, would make the appropriation amount of \$96,000 each year. One hospital requesting an appropriation received an income, last year,

from the board and care of patients, exclusive of payments by the State, in excess of its net cost of operation, a good business proposition for a charitable organization.

This leads me to suggest that you do not, as professional men, keenly interested in having a good hospital, readily accessible, encourage the establishment of small, weak hospitals in communities where there is not business enough to support them. It looks to me as if the time was coming when the Legislature would cease to look favorably upon the addition of more institutions to the list than it is called upon to assist. In fact, I know of more than one member of the Legislature, who, encouraged by the action of Massachusetts in adopting a constitutional amendment prohibiting any such appropriations, will be very likely to start something of this kind in Maine.

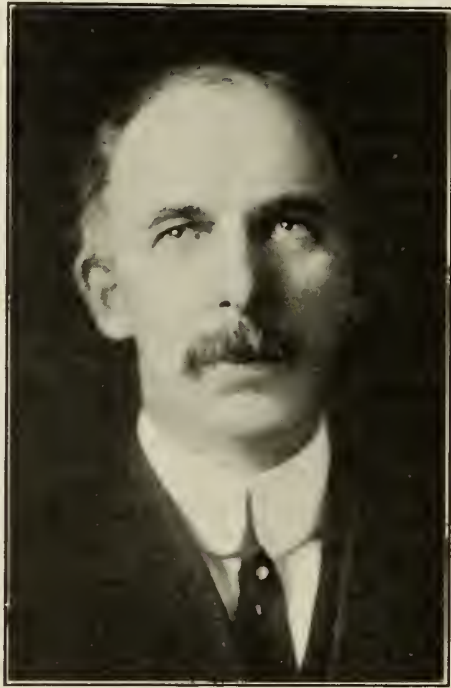
I believe we ought, those of us charged with the duty of providing plans for and supervising the expenditure of funds for the care of the socially inadequate, and those whose profession is the preservation of the public health, to be thinking *seriously* whether the time has not come when towns and cities should be permitted to provide, or pay for, hospital treatment for those who cannot afford to pay for it, without subjecting them to the disabilities and to the stigma of pauperism.

I wish I might talk with you further on this phase of the subject, but I have talked too long already. I hope that I have brought to your attention a few facts with which you were not already conversant. When you have had an opportunity to discuss this matter among yourselves, I should be very glad, indeed, to hear from some of you, or to talk with you. It does not make any difference to me whether you agree with the principles which I have enunciated in the earlier part of this talk, or whether you differ with me. I want your views just the same. It is the desire of the State Board of Charities and Corrections, and it is my desire as their executive officer, to give the people of Maine, whose servants we are, the facts with reference to their social welfare program, so far as they have one and so far as we are charged with its execution, to help them through their representatives in Legislature assembled to shape their future program, their blue print by which they are to build, and then to abide by that plan, to the end that the citizens of Maine shall lead in the problems of reconstruction which are now before them, the same as our boys in the Yankee division have led in the fighting, which was, to quote our President, "to make the world safe for democracy," and to quote our Governor, "to make democracy safe for the world," and to quote us all, to keep this good old State of Maine what we all feel that it now is, the best place in the world in which to live.

Necrology.

FREDERICK LYMAN HILLS.

Frederick Lyman Hills, the son of Dr. Lyman Henry Hills, still practicing at the age of 82 in Binghampton, New York, and of Margaret Williams Hills, was born at Schuyler's Lake, Otsego County, New York, October 18, 1870. He was graduated from the Coopers-town High School in 1887, from the College of Physicians and Surgeons



in 1892, and then entered Christ's Hospital, Jersey City, New Jersey, where he saw much obstetrical practice. He next spent a year at the Adams Nervine in Jamaica Plains, Massachusetts, and soon after was chosen assistant physician to the State Hospital for the Insane at Danvers, in the same State. He was invited to be assistant superintendent to the New Hampshire State Hospital for the Insane at Concord, New Hampshire, where he proved himself to be a man of rare mental poise and loveliness of character. In 1896 he married Miss Josephine Gilbert of Pittsford, Vermont, and is now survived by her and by a daughter and a son.

During his life in Concord, Dr. Hills became interested in the study of tuberculosis, showing, in point of fact, incipient tokens of that disease himself, and in company with Dr. Mitchell, of Lancaster, whom many in Maine well knew, he wrote and delivered many public addresses, illustrated with maps and charts, of this disease, and at the request of the Governor, he chose Glen Cliff as the situation for the New Hampshire Sanatorium for tuberculosis. During this period of public health work he won the Pray prize of \$100 given by the New Hampshire Medical Society for the best essay on tuberculosis and its treatment. After taking a suggested rest from his labors at the Loomis Sanatorium, at Liberty, New York, but where he worked as resolutely as ever, taking charge of one of the buildings and its occupants, he returned to Concord as "cured" and resumed his position in the State Hospital, and with it his studies on the insane.

In 1906, he was elected superintendent of the State Tuberculosis Sanatorium at Rutland, Massachusetts, at that time one of the largest of its kind in the nation, and filled that position with great ability and to the satisfaction of all.

Three years later, in 1909, he was chosen superintendent of the Eastern Maine State Hospital at Bangor, and began his labors there at once. That he worked conscientiously and effectively for the rest of his life, all who ever inspected that Institution knew full well. Enthusiastic by nature, and with widely founded administrative experience learned in years before, he brought this Hospital to a level comparing favorably with any other throughout the United States. Here he not only studied the causes and the possible cures for insanity, but he invented and developed educational industries for those afflicted, such as carpentry, weaving of rugs, entertainments for the Fourth of July and Christmas, agriculture, gardening, and the art of greenhousing plants and flowers.

Next we may say a few words concerning the unusual skill of Dr. Hills in the composition of medical papers for County and State medical societies as well as for popular delivery. Each of those that we have studied is well shaped, carefully balanced, and the English is especially remarkable for its chosen words and absence of repetitions. Amongst the titles available for mention here are, "One Hundred Cases of Insanity Tabulated," "What Must I Do to Keep Sane?" "Psychoses Following Surgical Operations," and "Psychiatry, Ancient and Modern," which was so attractive as to be accepted by the Popular Science Monthly. The paper on "Operations" is particularly good, showing the history of twenty-five patients, all undergoing ovarian, uterine or appendical operations without previous symptoms of in-

sanity, yet all exhibiting explosive insanity afterwards. In a paper on the "Causes of Insanity," mention is made of heredity, alcohol, drugs, infectious diseases and the bad housing of people with debilitated bodies. It is doubtful if the members of our Association really knew what a valuable man in mental hygiene we had amongst us for the seven years in which Dr. Hills labored in Maine, or if he received from the profession the recognition which he truly deserved. One of his highest aims was to treat the insane with a view to possible cure. No matter how hopeless the case appeared, he did not abandon some effort until he had convinced himself that nothing more could be done.

After all these labors came the war, in which he wanted to do his share, but his physical condition would not permit the much desired chance to serve the nation. He broke down, rested, came back again, gave up his work, resigned at Bangor, and spent part of a year at Pittsford, Vermont. Then, with advancing symptoms of nephritis, he went to a hospital in New York, and died there, July 20, 1918, from pneumonia.

Dr. Hills belonged to many societies devoted to insanity and tuberculosis; with us he belonged to the Penobscot County Medical Society and to the Maine Medical Association, and was an energetic and faithful member of each. He was ever courageous amidst the encroachments of disease against his own life, courteous as a man and physician, decided as an administrator, but always doing his duty in a manner to disarm criticism, thoughtful of others, unselfish to a high degree—in a word, he was a man of lofty ideals and purposes, and so far as his physical ability enabled him, he carried them through to the end. He possessed a profound discernment of humanity, was very skillful in psychiatry in its multitudinous moods and forms, and in psychical diagnosis. He welcomed visitors to his many hospitals to look about for themselves, and to answer their questions; he was, as one might say, an extremely well-balanced physician; not brilliant for a while with a light going out suddenly, but possessing a mind of steady, long-enduring, serenely-burning flame.

Some men can be embalmed in history with a very brief notice of an ordinary or an unsuccessful career; with others, you are compelled by the magic of their accomplishments to deliver something better than a mere perfunctory eulogy. Amongst such enlightened careers I add to our list that of the genial man, delightful conversationalist and writer, and skilled psychiatrist, who here receives from me, as necrologist of the Association, an all too brief encomium for his steadily progressive, ever advancing, and helpful work in the wide field of New

England insanity and tuberculosis, their study, prevention and cure. It is sad that upon that smiling face and sunny countenance we shall look no more.

J. A. S.

WALTER DARWIN WILLIAMSON.

Dr. Williamson died very suddenly, on Sunday morning, June 2, 1918, going to sleep the night before apparently as well as ever, but never again awakening to perfect consciousness. Whether he had any premonition of such an end, one sure to be a grievous burden to the dear ones of his family and his friends, we shall never know, for he



never mentioned it to anybody so far as can now be known.

Walter Darwin Williamson, son of Stephen and Ellen Ellingwood Williamson, was born at Milan, New Hampshire, March 11, 1863, and was, therefore, at the time of his death in his fifty-fifth year. His father was a studious man to a considerable degree, and hence the name of Darwin belonging to our friend. Young Williamson obtained an academic degree at the University of Vermont in 1885, and a degree of Doctor of Medicine at the school connected with that same University in 1888. He was a gold medalist in his class, and remained as bright as gold in his medical career. He had a post-graduate course in New York, and then settled for fourteen years in Milan and Berlin. On the death of Dr. Henry P. Merrill, of Portland, in 1902, at that time surgeon to the Grand Trunk Railroad, Dr. Williamson removed to Portland for the remainder of his life, and likewise occupied that same important position.

He soon obtained the appointment of surgeon to the Maine General

Hospital, and very rapidly made a name for himself in Portland as an honest medical adviser and a skillful surgeon, fertile in resources as an operator. He gave much study to surgery, was not contented with what he knew from observation and experience, but he visited the famous surgical centres in the United States and made himself a master of the highest surgical technique. He was a man of kind disposition, and although with an apparent gravity of countenance, his smile was rapid on occasions deserving of mirth. His features reflected steadfastness, determination of purpose, fixedness of character, and these traits were still delineated upon his face as we looked upon it for the last time. He was a manly man, as one might say, and one who was always looking ahead to a success in life, but never at the expense of others in medicine.

As a physician, Dr. Williamson did not write much, but his occasional papers were deserving of high consideration, and in discussing the papers of others he kept to the theme instead of wandering afield in other provinces of medical thought. His offices were many in medical societies, and he filled them capably.

He married Miss Harriet York, of Milan, February 15, 1900, and is by her and a daughter survived and mourned. At the last meeting of the House of Delegates of our Association, it was unanimously voted that resolutions of regret, admiration and respect should be sent to the widow and daughter of our comrade in medicine. This was done at once by the President of the year, and now we have to add this concluding paragraph.

It is very difficult to depict the character of a man whom we all knew so well, who was with us intimately, who left us so suddenly and whom we all not only liked, but admired. But as a mere outline sketch of one worthy of many more words than we have easily at hand, let these few sentences be offered to the members of the Association, and to the readers of the JOURNAL, as a very imperfect appreciation and memorial of a man of the highest rank in medicine, in surgery, and in brotherly friendliness to his colleagues.

Book Reviews.

Autointoxication and Intestinal Toxaemia.

By Dr. J. H. Kellogg, Battle Creek Sanitarium. Price, \$2.50.

The intention of this book is to present in its intimate details the practical, scientific, rational, and nevertheless, simple methods so successfully used at this famous sanitarium for so many years. It is a book easy to read and comprehend, and from personal interviews with patients in Maine who have followed these ideas out, to success, we are assured that they are valuable in the extreme. The milk, the fruit, and the antitoxic diets are fully explained, and followed with various suggestions for additional treatment. It is well printed and easy to handle, and will prove valuable to physicians of internal medicine

Transactions of The College of Physicians of Philadelphia.

Thirty-third Series, Vol. XXIX, 1917.

This handsome volume of some 500 pages is asking for notice from us, and such indeed it shall have, for in a long time we have not read a more delightful set of Transactions. Beginning with an address by the President, with the business and deaths for the year, a large number of excellent surgical papers follow. Amongst these we note with particular interest three on fractures, orthopaedic surgery and plastic operations in American base hospitals abroad. Syphilis and the nervous system come in for good papers, with suggestions for treatment from laboratory experiments and physiological syndromes. Three papers are devoted to pneumonia in Philadelphia, specific treatment of lobar pneumonia, and the clinical aspects of the disease. The surgeon will naturally turn to three papers on the gall bladder, and the sociological physician to a paper on "The Threat to National Efficiency from Ill Health." We note also with especial interest a paper on a cancer operation upon the late President Cleveland, although we see no reason for secrecy in not printing the photographs exhibited at the time of reading.

The appendix of this book is also rich in papers on ophthalmology and allied specialties, and we commend especially one on the relations between the eyes and the ears, as shown by aviation tests for equilibrium, and a second on intracranial complications from eye and ear diseases. The section on nasal operations has an excellent paper on deviations of the septum, but there is not much said concerning the apparently frequent connection between this operation and the appearance of subsequent and fatal attacks of meningitis. Sixty pages on industrial medicine and public health, and a very fine paper by Dr. McIntyre on "Science and Shekels" (in abstract only, we regret to note), bring a noteworthy volume to a close. This is a book well worth investigation amongst the hosts published, not only nowadays, but bound to be printed so long as literary effort compels some men to write out and print their burning thoughts, with hope of adoption by others of the profession.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.**EMPLOYMENT OF EXPECTANT MOTHERS IN A MUNITION FACTORY.**

Every physician interested in the welfare of pregnant women should make an effort to follow out the studies going on in Great Britain to conserve infants about to be born. Even if women have so far been employed but little in this country during the war, they will come more and more into factory work of various sorts as time proceeds, and physicians should study what is being done abroad. In this direction of thought, we note a very pertinent paper in the *British Medical* for Sept. 21, 1918, by Dr. Rhoda Adamson, who has gone deep into this question during the past four years. She unveils in the paper before us the work accomplished in munition factories since April last, long enough to show the value of care of pregnant women who wish to work so long as it is safe for their infant.

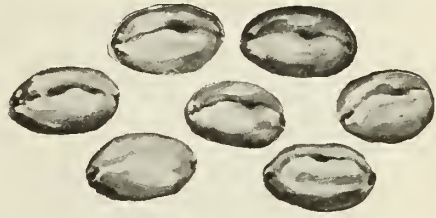
The first point emphasized is that pregnant women must not have night work; it fatigues them over much. Immediately upon notification of expected pregnancy the woman is shifted to light day work, and removed from any munition process calling for heavy lifting or sudden strain. Lathe work, for instance, involves these two issues, and pregnant women are at once excused therefrom. They get light sedentary work, such as putting fuse parts together, until the end of the seventh month, when they go to the general clothing shop and sewing depot, working on overalls, caps, gloves and so on, for the use of other

workers. The last hour of the day is given to sewing for the baby clothes with the help of hand sewing machines and the pressing of a gas engine. In the sewing room, such women are encouraged to lie down at intervals; they are furnished with low worktables and chairs and stools; they get an extra pint of milk in the middle of the morning and a two course dinner as a gift from the management. The woman medical officer assigned to the factory visits once a week the sewing department where these women work, examines for albumin and gives advice where apparently needed.

One great advantage so far gained has been the early notification of pregnancy, for now that the women know that their condition will not put them out of work, there is no longer need for concealment, and less anxiety to produce abortion before pregnancy might be suspected. The women now seem contented, and their only anxiety is lest they should fail to obtain employment when the baby at last comes along.

It is, in the opinion of Dr. Adamson, too early to dogmatize concerning the condition of children thus born, but the general well being of the expectant mothers is very apparent. Possibly the work can be enlarged by admitting to the factory work rooms expectant mothers from outside.

We most heartily commend to our brothers in medicine this all too brief paper; for it ought to encourage other nations to follow the example given, and it cannot but lead to decrease in miscarriages, diminution of after-effects on the mothers, and decrease in infant mortality, ante-natal as well as after proper delivery.



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(3011)

INTRAVENOUS INJECTIONS OF IODIDE OF POTASSIUM.

Simon has lately brought forward a suggestion to utilize intravenous injections of iodide of potassium, and we suppose that iodide of sodium will soon be utilized in the same fashion. Originally, five centigrams of the salt were used in each cubic centimeter of water. Later this has been increased up to a dosage of gm. 0.90 in watery solutions. Patients perceive a peculiar taste in the mouth and a sensation of cold gas exhaled by the same channel. Slight pallor was noticed in one instance. Iodism has never been produced. It is too early to know what greater results, if any, over the mouth induction of these salts have been obtained. It would hardly seem as if much usefulness appertained to the proposed method, when these drugs can be so well borne by the mouth and stomach. Possibly in the venereal the blood might be more rapidly affected by the intravenous method. At all events, it seems well worth mentioning and recommending for study and practice; it certainly keeps the patients under better control.

MEDICAL SUPERVISION DURING PREGNANCY.

This important topic of public health has received much attention at the hands of foreign, especially British physicians, during the war, and in addition to numerous papers to which we have called attention before, we now take pleasure in annotating a good article on this topic by Routh in the *New York Medical Journal*, Nov. 16, 1918. In this he writes from the standpoint of approximate percentages of the causes of ante natal, natal and infantile deaths. These are tabulated under syphilis, toxæmia, prematurity, prolonged, complicated labor, ante partum hemorrhage and other minute causes, known or unknown. He then emphasizes syphilis, and the accidents and complications connected with childbirth. The precise meaning of "prematurity" needs to be made uniform, and the suggestion is offered that it should mean infants born before the thirty-eighth week of gestation. The statement is then made that in England and Wales 27,000 infantile deaths occur yearly from syphilis during the ante natal period and the first month of life. After various statistics in this direction, a brief study is offered of congenital syphilis and of its gravity from all points of view. Maternal treatment with mercurials in the early months of pregnancy will usually ensure a healthy child, but the treatment should also be carried out in subsequent pregnancies.

Mention is next made of stillbirths, as well as of the causes of death a few days after birth from accidents or complications. Of these, in detail, it is shown that many could have been prevented, or lessened, by medical supervision during pregnancy.

Finally, the author appends a list of 218 operations in contracted pelvis, with a maternal mortality of 3% and infantile of 26%. Inasmuch as compulsory notification of pregnancy is, at present, out of the question, education of women to enable them to realize the need of supervision during pregnancy should be the aim of the profession on every opportunity.

NEW AND NON-OFFICIAL REMEDIES

During January the following articles have been accepted by the Council on Pharmacy and Chemistry for inclusion with New and Non-official Remedies:

Dermatological Research Laboratories:
Neoarsenobenzol.

Guiseppe W. Guidi:
Ittiolo.

Merck and Co.:
Digitan.
Digitan Tablets, $1\frac{1}{2}$ grains.
Quinine Ethyl Carbonate-Merck.

Monsanto Chemical Works:
Chloramine-T, Monsanto.



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County News and Notes.

YORK COUNTY MEDICAL SOCIETY.

The 95th quarterly meeting of the York County Medical Society was held in the Common Council Room, City Building, in Biddeford, Thursday, January 2nd. In the absence of the President and Vice-President, the meeting was called to order by Dr. F. E. Small, of Biddeford, who was then elected chairman.

The business section of the meeting was opened at 12.30 P. M. The records of previous meeting were read and approved, and Dr. J. D. Haley, of Saco, and Dr. F. C. Lord, of Biddeford, were appointed a committee on nominations. They reported for President, Dr. A. T. Davis, of Springvale; Vice-President, Dr. F. W. Smith, of York Village; Secretary, Dr. A. L. Jones, of Old Orchard; Treasurer, Dr. C. F. Traynor, of Biddeford.

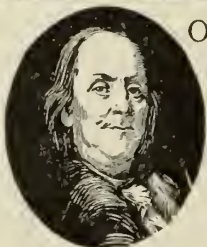
Dr. F. E. Small was chosen a member of the Board of Censors for three years, and Dr. D. E. Dolloff, of Biddeford, delegate to the Maine Medical Association. These men were elected in due course of ballot, and we note that Dr. A. L. Jones is now nobly serving in his eighth year of the Secretaryship. The Treasurer's report showed a credit balance of \$109.69.

Dinner was then enjoyed at the Hotel Thatcher, and the afternoon session was opened at 2.00 P. M. The symposium on "Influenza" proved highly interesting and instructive, and a very spirited discussion followed, every member present participating and each contributing some valuable information concerning the best sort of treatment, as he happened to find it.

Dr. Carl M. Robinson, of Portland, was the guest of the Society, and he presented an admirable paper on the very timely and appropriate subject: "War Surgery as Applied to the Problems of Civil

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Practice." Dr. Robinson explained several modern methods of treatment developed during the progress of the World War. A rising vote of thanks for his excellent address was extended to the essayist.

The following members of the County Society were present: J. O. McCorison, North Berwick; J. D. Cochrane, J. D. Haley, C. E. Thompson, Saco; H. L. Prescott, Kennebunkport; W. W. Smith, Ogunquit; J. C. Stewart, York Village; B. F. Wentworth, Scarboro; A. C. Lamoreux, Sanford; C. J. Emery, D. O'Neil, A. C. Maynard, F. E. Small, C. F. Traynor, G. C. Precourt, F. C. Lord, Biddeford; J. A. Randall, A. L. Jones, Old Orchard. A. L. J.

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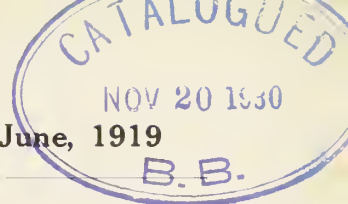
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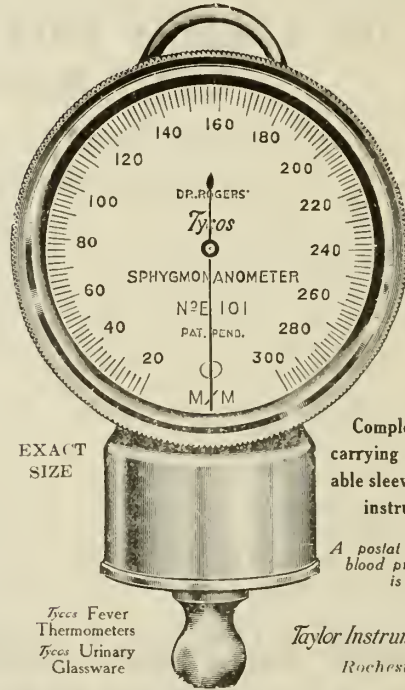
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OF THE

Maine Medical Association.

Published under direction of the Council of the Maine Medical Association.

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The Journal assumes no responsibility for opinions expressed by the authors.

VOL. IX.

MARCH, 1919.

No. 8

*THE EYES IN WAR.

By DR. JAMES A. SPALDING, Portland, Maine.

A few moments after a most unexpected election to the Presidency of this Association it occurred to me that there was no topic upon which I could speak more freely or convincingly than the one which I have just read to you, "The Eyes In War." During the year that has passed since this title flashed across my mind, I have given to it much thought and study, and here you have their results.

When men first came upon the earth they used their eyes to take a look at the land in which they were living, and after becoming used to views at a distance, they looked at things nearer at hand. They saw precious stones, gold, and lands for cultivation, and finally they saw women whom they wished in marriage. Yet when they tried to possess any of these precious values they met with opposition, anger, and finally violence from others on the same things intent, and fights ensued between two opponents. In other words, a mimic war became something new upon the surface of the earth.

Travelers of the twentieth century reaching the outlying fountain-heads of the Amazon or the Congo rivers will tell you of hand-to-hand combats which they have seen between savages of those regions for the ownership of gold, or precious stones, or a wife. They mention in their books the scratching, clawing and biting of the combatants, and the injuries of the eyelids, and of the eyes themselves occurring during such brawls. Although between two men only, these contests are as truly

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war as if thousands were engaged, for no matter how enormous the forces employed in battles nowadays, it generally comes to this, in the end, a hand-to-hand fight with the butts of rifles, bayonets, or fingers and finger nails of the few survivors, opposing one another in pairs, and trying to maim or to kill.

Just as in the twentieth century savages fight from envy, anger, hatred or longing for ownership, so in the beginning of the world, savages fought for similar reasons, and met with just that same sort of injuries around the eyes as are seen to-day, amongst savages hardly yet more civilized than our most remote ancestors. War nowadays is a battle to the end between two sets of men, the arrogant and the high hearted. It was so then, and it is so now, the aim of both being to knock out an adversary in a war of two, by injuring the eyes, so that the other cannot see how to deliver his blows. Now, however, we fight with a greater refinement of cruelty, and with infinitely greater force behind the blow, than in the early ages of the world.

It is not for me to prove that in primeval battles the eyes were seriously injured, nor could it be really proved, but from study of prehistoric skulls, it is plain that in many of them fractures of the orbit, and the extension of fractures into its cavity behind the eyes, shows beyond a doubt that owing to blows producing such fractures, the eyes must have been tremendously injured, even if not totally removed.

No sooner had the weaker men of that era learned that the brutal were bound, from their nature, to fight, and to destroy any part of their bodies that their hands and finger nails could reach—for even then finger nails had been so savagely sharpened as to be able to dig out an eye—they turned to a study of self-defense. We cannot doubt, then, from this point of view, that boxing with the fists for protection to the face and eyes was early learned. Failing, next, to beat down this scientific defense, the pugnacious utilized the roots, branches, or stumps of trees, armed them with flints or bits of native copper and then exhausted the defense of the boxers. Oddly enough I note just here that the Africans used to dip their war clubs into the extract of the calabar bean, from which eserine is made, and with this poisonous adjunct they felled many of their enemies. So in a fanciful way we may suggest that eserine-infected wounds of the eyes go far back in the history of drugs in this world.

Hand to hand no longer, but club against club, the weaker discovered visors and shields of various sorts, made from metals, shells or skins of animals. Without detailing all of these devices, it may be said that man continued from the earliest days of the race down to our times to find new methods of attack and new methods of defence; that

this ideal continues and that it will endure forever, the ingenuity of one set of men trying to outwit the brutality of another.

Great was that day for the weaker when the first man discovered the art of throwing stones at an enemy and from a safe distance. Instead of fighting back to the wall, he learned to get away, and to fling a stone on the chance for a hit. Without really knowing it, the man who had found out how to throw a stone, had learned how to hit a harder blow than with his fists, and at a greater and a safer distance than the length of his arm. Used first to kill wild beasts for food, the art of throwing stones was soon utilized in war, hand to hand or army to army.

From throwing to slinging stones was but a step, and the skill obtained by slingers at a distance of a hundred feet or more became extraordinary. Slingers became a very large part of every army, and hundreds of them, as the Bible tells us, were left-handed. David hit Goliath in the middle of the forehead, but he could just as easily hit him in the eye had he wished.

As time progressed the value of the eyes for existence came largely into Legend, and we find their pricelessness emphasized in the story of Argus, with a hundred eyes, ready for every surprise, each one useful to take the place of another if weary or injured, and in the romances of the Cyclopedes, probably arising from the story of a warrior who had lost an eye in battle but still remained a doughty champion fighter. Then again, Polyphemus, with his single eye, is familiar to us all, and his fate is typical of the one-eyed, who, when that one eye is injured or destroyed, is helpless in war.

Looking into early historical facts concerning injuries of the eyes in war, we note how Philip of Macedon, during a siege of a walled city, was hit in an eye by a famous archer, named Aster, who tied to his arrow this label: "For the right eye of Philip". The arrow hit Philip, indeed, but failed to penetrate the brain, and Philip lived longer but with a single eye. Look at the portrait-statue of Alexander the Great, and note that the head is tipped backward a bit, and to one side a trifle and from that position we know as well as if we were in our consulting room that he suffered from double vision, due to a war injury of the orbit. Although the blow did not hit the eye, so far as we know, double vision ensued from ocular paralysis, and in order to avoid the confusion to the sight thus produced he held his head curiously as mentioned, and then saw but a single object with both eyes alike. We might even predict that he suffered from paralysis of the obliquus inferior of the left eye. Those who recall our late comrade, Dr. Merrill, will remember the similar odd fashion in which he held his head to escape a very annoying double vision from similar ocular muscle paralysis.

Bows and arrows go far back into antiquity, and are mentioned in Genesis, 2,000 years before Christ. Alexander the Great knew an archer who could fly an arrow through a finger ring at one hundred yards. Long bows were six feet in length and could throw an arrow three feet long four hundred yards. Robin Hood flew an arrow six hundred yards. Walter Scott relates marvellous feats with the bow, and tells us of Locksley splitting with his arrow a willow wand an inch in diameter at one hundred yards. Arrows were tipped with flints, or metal, and thrown also from cross bows or machines with springs. At the battles of Bannockburn, Crecy and Poitiers, in the thirteenth and fourteenth centuries, archers were largely employed, and injuries of the eyes are mentioned in ancient chronicles. Bannockburn, by the way, is the first battle in which trenches figured, but here they were merely camouflaged with boughs of trees, so that the enemy's cavalry fell into them and were discomfited amidst the tree branches thus utilized.

Antique tapestries in museums show to the curious searcher for facts concerning the eyes in war, pictures of soldiers staggering across a battle field with an arrow fast stuck in an eye, whilst comrades try to pull it out. Mediaeval hospitals contain records of injuries to the eyes, but nothing more definite than that "the eye of the soldier was hurted in battle and ran out."

Bayonets, pistols, gunpowder, dynamite and revolvers came into military use at various times and added to the list of eye injuries, into the multitude of which we cannot here inquire, but will note as we go along. Although revolvers of Colt appear as novel in 1835, revolving cannon with eight chambers were used five centuries earlier. Killicran-kie battle in 1689 is said to have been the first in which the eyes were penetrated with bayonets.

With the discovery and utilization of gunpowder there came a great change in the variety of wounds of the eyes. With greater force behind, greater damage ensued. As protections, chain and steel armor helmets and visors for man and horse were invented, and as practice for war hand-to-hand combats, joustings, and tournaments in armor were held in public.

At this point we are led to study the curious historical interest attaching to injuries of the eye in tournaments and battles, the termination of which changed the course of nations and the fate of people. To celebrate a royal wedding in France, in 1559, there was a tournament, and Henry II, the King, had carried off three successive duels on horseback. Armed head to foot, the horses likewise, the two champions, with great beams of wood covered with plates of iron and resting on the pommels of their saddles, dashed away from either end of the field and

hurled themselves with whirlwind speed and terrific impulse against one another. Henry, unsatisfied with three victories, insisted upon just one more duel. Owing to some carelessness of his master at arms, the visor of his helmet was not properly fastened down, the beam of his opponent, Montgomery, hit him square on the helmet, raised the visor, hit the right orbit, and then grated along and entered the left eye. The King fell unconscious, and remained so until his death, ten days later. Ambrose Paré, of whom we know, and the famous anatomist, Vesalius, were sent for, and many other surgeons also. The brains of four freshly decapitated criminals were opened to discover a possible diagnosis and treatment for the monarch, but all in vain. The post-mortem examination revealed destruction of the left eye and a cerebellar hemorrhage, with incipient softening.

Now note how that eye injury in mimic war changed the whole history of France. His successor, a boy of sixteen, had just married Mary Stuart. He came by this accident into the kingdom of France most unexpectedly, but died very soon from acute mastoiditis. Had Henry II lived, this young Francis never would have been King at all, his successor, a boy of ten, would never have had a Catherine of Medici to rule France and bring in St. Bartholomew's day, and all the Huguenot horrors, to say nothing of England and her anxieties concerning Mary, Queen of Scots. I note, as I leave this story, that the French surgeons of that era knowing nothing of the treatment for mastoiditis, let young Francis die without an operation, and oddly enough the death was attributed to the pouring of poison into the ear by a hired assassin.

Again in 1610, the eyes had something to do with the assassination of Henry IV of France. After escaping eighteen attempts, he fell by the hand of Ravillac, who jumped up on the carriage steps, reached through the window and stabbed the king mortally. Sitting alongside the King was Marechal Roquelaure, who had lost an eye in war and did not see the murderer as he reached through the window. If the old Marechal had been sitting with his good eye toward that fatal window he might have prevented the assassination, and the later history of France would have been different.

Last of all, I recall Charles XII of Sweden, famous for all time, who was killed in December, 1716 whilst the postmortem examination was only scientifically made two hundred years later, in 1917. This man has come down to us as the victim of an assassin. According to others, he was killed in the trenches. When the coffin was opened in 1917, the body was found well preserved, and examination showed that the outer margin of the left orbit and the left eye itself had been destroyed by a bullet. The fracture extended to the right for three inches,

the loosened bone being still held in situ by the skin, but the missile had escaped outside, through the right temple, and was not to be found. This examination proves that death resulted from a bullet much more in front from an enemy than from behind by the bullet of a murderer. So ends the mythical confession of a Secretary Squire. Here is another lesson of how injuries of the eyes in war have changed the course of nations, for had this monarch lived, the history of Northern Europe would have been far different, because he was one of those men who make history every day of their lives.

About this same time the Duc De Berri was hit in an eye with a buckshot ricocheting from ice when he was crossing a frozen river in retreat. And later on another notable, Neipper, who married Marie Louise of France, lost an eye from the penetrating point of a sword in battle. Other famous men might be added to this list to prove that one-eyed men have done great things after this incapacitating injury.

Coming to the Napoleonic era—and thanks to Baron Larrey and his surgical memoirs of all those great battles—we read of injuries of the frontal nerve producing blindness in an eye without actual destruction of the organ; of sword injuries affecting the nose and orbit with loss of sight; and of a case in which the orbit was wounded by a penetrating injury followed by pus and bulging forward of the eye, with blindness. When the pus was evacuated, sight was restored. Larrey also mentions military injuries of the tear passages and many incised injuries of the orbit, eyelids and eyeball, with recovery. Finally, he reports three cases of death from a cavalry lance penetrating the orbit, eye and brain.

A study of eye injuries during the American Revolution of 1776 and the war of 1812 reveals nothing more serious than burns of the eyelids and eye from flashings of powder from old-fashioned flintlock muskets or from bits of flint itself. It was at the Battle of Bunker Hill that our soldiers were ordered "not to fire, boys, until you can see the whites of their eyes", and we wonder what relation such a standard of vision would bear to the reading of test types in the offices of surgeons of today. Would 20/20 in each eye hit those eye whites?

A relative of my own, an officer fighting in the war with Mexico, once told me of seeing two men injured with bits of percussion cap flying into an eye in each of them. Such injuries are now practically unknown.

The Crimean War has long since passed out of mind, yet it should be perpetually recalled on account of the memory of Miss Florence Nightingale, the first trained nurse in history. Very small attention was paid to the eyes in this war, but there were many rifle pits from which sharpshooters on both sides took their chances for eye injuries,

to which, however, but crude attention was surgically given. These pits were the forerunners of the trenches of to-day, and trench fever was to blame for an enormous mortality at this time. Prince Orloff, later an ambassador to London, lost an eye in the Crimea from the thrust of a bayonet in a hand-to-hand combat. Perhaps "The Charge of the Light Brigade" will recall better than any other item, the blunders and miseries of the Crimean War.

The history of eye injuries during the Civil War of 1860-65 has been well written, and the first noteworthy point is the very large number of cases of sympathetic ophthalmia. Many eyes, too, were enucleated in this war, but despite the operation, sympathy followed, because the operation was done too late or too dirtily. Amongst the twelve hundred annotated injuries to the eye in this war, I note two of total blindness from a bullet passing through both orbits and wholly dividing both optic nerves.

There are also records of forty shell explosions destroying one eye totally, the other escaping, and the right eye being oftener injured than the left. Trench fighting was, practically speaking, unknown, except in the last year before Petersburg, Virginia. Men mostly stood up as marks, and many eye injuries occurred of minor nature. Helmets and visors were unknown. In one instance, both eyes were destroyed instantaneously by a shell exploding. In most of the instances in which the eyes were destroyed by explosions, the soldiers ultimately died. Many eyes were injured by buckshot, causing a small, but dangerous, perforating wound, endangering the sight, and the fellow eye, by sympathy.

During the Franco-Prussian war of 1870, more notice than ever before was taken of eye injuries, because the specialty of ophthalmology was by that time firmly established as a part of surgical practice, and the many instances of sympathetic ophthalmia in the Civil War, previously, had taught the lesson of earlier and more careful enucleation. Breech-loading rifles, also, were widely employed, and many eyes destroyed by their blocks blowing out, or the gunpowder burning the lids and eye. Soldiers with eye injuries were for the first time carried to the rear and put in charge of ophthalmic surgeons. The left eye was hit much more often than the right, due, as was surmised, to the better protection furnished to the right eye by the butt of the rifle. It was now first observed that if an eye suppurated after an injury, it was much less likely to induce sympathetic ophthalmia than if insidiously inflamed. Sutures were also now first utilized for sewing over extensive injuries of the sclera, and with unlooked-for good results, many an enucleation being thus avoided. A man of whom I lately heard, lost the

sight of an eye totally, the bullet lodging in the orbit and only being removed at death, thirty years later. In another instance, a soldier was hit in the right eye, without apparent injury, but could never afterward "see but half of objects with this eye." Dynamite and gun cotton explosive injuries were studied, and strychnia utilized hypodermatically for optic atrophy following concussions without material injuries. Much was said of the early or late operations for traumatic cataract, and first aid bandages, covered with aseptic ointments, for protecting orbital, eyelid or other injuries, were utilized in military surgery at this time.

With the war of 1914 we find so enormous a catalogue of ocular injuries, that the mind staggers beneath the multitudinous items offered for study. Leaving aside for the specialists the infinite minutiae of many, let me pass before your view some salient points of value to general practitioners. Trench warfare has produced a greater percentage of war eye injuries than ever before. Standing deep in pits, more than six hundred orbital injuries alone have been collected by one observer, and the eyes have suffered from sand, parapet dust, gravel, clumps of earth, and bits of shell and grenade. But helmets, visors, masks of steel and Cruise's non-rustable ring veil have kept down serious injuries perceptibly. In no war have enucleations been so few, proportionately, to the large number of injuries.

Ever since gunpowder was invented, there has been much curious talk about the effect of "windage" on man. We have read of men dying from the windage of shell. Loss of sight from the same cause has been mentioned but shrugged aside. Nowadays, however, nobody doubts aerial concussion of the eye with internal hemorrhages any more than he doubts brain hemorrhage from the same cause. The air compressed by the immense size and velocity of modern projectiles does great damage to the sight without touching the eyes. Choroidal ruptures, with hemorrhages, from this cause are often mentioned. Final proof of the enormous compression of the air by modern projectiles is furnished by aviators, whose airplanes are tossed to and fro with impressive violence by the compressed waves of air passing alongside them from high-flight projectiles. Coming, as they do, close to soldiers, it is undoubted as a fact that aerial concussion of the eyes, with loss of sight, and without direct injury to the eyeball, can no longer be denied. Then, again, we have the curious study of ocular hemorrhages, caused by projectiles passing into and through the orbits without rupturing the coats of the eyes.

It may create a smile amongst you to speak of whip injuries to the eyes in the present war, but cavalry is still in use, and horses and mules still haul artillery and supplies to the front. So long, then, as they need

the whip, so long will whip injuries of the eyes, abrasions of the cornea, and prolapses of iris occur.

In the list of curious accidents to the eyes I note at this point bits of sand penetrating the cornea and resting sparkingly upon the iris, but without interfering with the function of the organ. Mention of foreign bodies within the eyes reminds us that in this war giant magnets have failed, in comparison with their success in civil life, because so many of present-day foreign bodies are non-metallic. Another novel eye injury of the era is due to gassing, the irritating substance producing conjunctivities and ulcers of the cornea. To this item may be added the utilization of ipecachuanha, soap, snuff and other irritants rubbed into the right eye to produce an artificial defect so as to free malingerers from duty on the battle field. Many instances of hysterical amblyopia and blepharospasm have lately been discovered and discussed.

Attention is now called to night blindness, in which the soldier sees well by sunlight, but is practically blind after sunset. The retina loses its perception from trench life, scurvy, poor nutrition and low vitality. A study of the causes of this affection is gradually bringing about a needed cure, for it is plain that a night-blind soldier would be useless in night attacks or as a sentry on duty.

Extraordinary, also, are those losses of sight in which the eyes have not been injured, but in which we find fracture of the skull or orbit, with odd-shaped defects in the field of vision, not only as of old, right and left, up or down, but spirally and in one or more different sectors. These have become a topic for study.

I have already said, but I will here repeat, that as fast as some men have discovered means of destroying the sight, so others have invented means of protecting it. Helmets and masks are good, but Cruise's veil of rust-proof rings seems, so far, the best protection. Through its interstices the soldier can see, when the veil is attached to the helmet, and the slight "give" to the whole structure keeps out small pieces of metal or mineral which might destroy an eye or excite sympathetic ophthalmia. Another invention, resistall glass, made by welding between two layers of glass, a layer of celluloid, the product resisting the bullet of a revolver at a distance of twenty-five yards with an initial velocity of 2,700 feet a second, has promising value in war.

Amongst modern curiosities in the way of ocular injuries are those "boring" accidents, the bullet twisting more than ever, owing to excessive rifling of the gun barrels, so that an eye hit with but small force spreads out like the petals of a flower. So, too, we note psychogenous loss of sight, where the soldier has become nervously benumbed by drum fire, or a bomb or shell has fallen within a few feet of him, but has failed

to explode. Here the sight is lost from fear. So, too, with shell shock, after actual explosions close at hand, the sight is lost, or the fields of vision so much contracted as to make the soldier useless for war. It has, however, been noted that many such men on their way back to "Blighty" have recovered their sight when their hospital ship has been submarined, for the new shock, the new terror, the anxiety for life, annihilate the psychical effect of the former shock. Some hysterical eye affections come in under this list. Trench nephritis is a new form of military kidney disease, and with it has been observed a new form and distribution of retinal blood clots and exudates. Another novelty is eyelid burns and ulcerations of the cornea inflicted by liquid fires, and caustics, never before used in war until these atrocious days.

Amongst ophthalmic lessons of the war, we note that it is useless to irrigate the bottom of the orbit without sterilizing the walls; that with a telephonic apparatus we can better than ever before discover within the eyes foreign bodies of which otherwise we get no trace; that a conjunctival flap saves many an eye; that enucleation is less needed than of old; that never should both eyes be removed at once for fear of insanity; that eyelid transplantations are magically performed, and that dionine dropped into the eye, or litmus paper pressed between the lids, or a subconjunctival injection of copper sulphate, are surer signs of death than anything yet discovered.

This war has thrown invaluable light on the absurdity of sight testing with letters, in comparison with the military wonders done by men found defective with such tests. Many men, soldiers once, are officers now, yet they barely passed the letter tests. Many had but half of what America demands, yet now they are leaders of men, instead of being, as with us, leaders of slackers. Many nations have different standards for types. Many soldiers never aim at all, but holding their rifles at hip they let fly, and somebody is killed or wounded without the need of sight. In many night attacks, vision is of no value. Men with poor sight for letters have fought with honor, lost more sight, recovered some, and gone over again and killed more Huns with bad eyes for letters, than men with perfect tests.

It is time that we had better standards than test type. Who knows whether they should be black on white, or white on black; complete letters or with parts cut off; be seen under cover or out of doors; on a bright day or cloudy; illuminated by a window or artificially; if artificial, should it be gas, electricity or lamps; and should the light shine on the paper or from behind through a transparent curtain. Fighting soldiers do not stand still to be aimed at! They are on the move! Ought we not, then, to choose for eyesight testings moving pictures of men,

horses, tanks, animals, and of different colors and brilliancy, rather than the alphabet. Or take a soldier 5 feet and 6 inches high. At what part of him are you going to aim that shall be equal to the dimensions of 20/20 test type! Better set up a picture of a soldier, marching, and let the eyesight test be the buttons sewed on various parts of his uniform. Nor again in tests by letters are we to forget foreign illiterates, many of whom have no idea of even 20/20 English type, but who, physically, would make "bully fighters," as somebody has said. Then again, how different are the eyesight requirements of cavalymen soldiers, ambulance and motor car drivers, men with heavy artillery, and drivers of mule teams. We carry too far these mere test-type eyesight tests in comparison with what soldiers have to do with what sight they have. Nor should we ever forget how the defective sight of many men can be improved wonderfully by squeezing together the eyelids. Intelligence also talks, and a man with brains, but with medium sight, makes ten times a better fighter than a lout with 20/20 in each eye. Nor again, as wise men, are we ever to forget the results, of seeing "the whites of their eyes", in history.

Much has been said about the ears and the equilibrium of aviators. How many competent men, as later proved, have been turned down out of the revolving chair, because their balance tests were defective. But after two years of all these experiments we are now assured that balance tests amount to nothing, but that what we want is perfect sight in both eyes, perfect muscular balance of the eyes, and above all binocular vision, the ability to use both eyes as one at once. The aviator must see far, he must see well in the bitter cold of high altitudes, amidst fog, clouds, mist, rain or in the shining of the sun. He must, in a second, see the dials of his machine, and in another look afar at an approaching enemy. He must see well to take instructive photographs, he must have good color vision to recognize signals and flags, but first, last and always he must have equal sight with both eyes, so as to understand distances, and by that skill to hit an enemy's airplane destructively, and on every occasion to make a good landing on the earth, so as to save his own machine and his own life.

Color vision also for land and for sea has been studied in these days as never before, and improvements made in tests. Scouts, sailors, aviators; think how the safety of the ship and of their comrades on sea and on shore depends on perfect recognition of colors and proper answers to signals observed. Yet our tests often fail, because they do not rely enough on war conditions of lanterns and flags.

The wearing of lenses in war should not depend so much on the need of seeing better with them as of feeling better with them on. The

user of spectacles asks, first; that they reduce the irritation of the lids and prevent headache, and nipping of the lids. Extra sight is secondary. If lenses must be worn they should be set in spectacle frames. The soldier or sailor should have a duplicate pair, and leave with the surgeon in charge a duplicate formula in case of loss or breakage. Thus equipped a man can do good service for the nation, but he ought not, without them, to fall much below the standards lest emergencies destroy all of his lenses, and he be left stranded without much sight.

Great successes have occurred in the war in the building anew of shattered faces and orbits, and extraordinary results have been obtained by skin graftings and implantations. In ancient days eyes were painted on leather, wood, or shell and hung over the vacant orbit with a cord. Later the eye pictures were made smaller, and pushed between the lids, and finally eyes of glass were used. Nowadays deformities of that sort are filled in with gutta percha, painted and enameled, and artificial eyes are attached to spectacle frames, and all is done so skillfully that unless one looks very carefully most of the former horrible deformities have disappeared.

Without detailing a hundredth part of all that might be said concerning the eyes in war, let me here reiterate the main idea of this paper; that from time immemorial the eyes have been injured in quarrels of all sorts, and that as such injuries occurred, methods of defense were invented. In spite, however, of all that we can do, injuries will occur so that the study of their cure will forever be worth the efforts of the keenest minds in medicine.

Another purpose of this address would not be fully accomplished did I not now emphasize the lesson which it ought to teach us; our duty to comrades in medicine who return from the war blinded in one eye, or in both. Although a one-eyed physician may earn a living as before, we must not forget the deformity attached to the man with but a single useful eye. Even if it remains in place, yet has a scar, or if it has been removed and an artificial eye is worn, people will learn of it, and there will always be people contemptible enough to refuse to employ a physician so disfigured. Worse than that, they will decry the mutilated man to their friends as unworthy of employment, because he has only one eye. Now I say to you, keep your two good eyes on the one-eyed physician coming home from the war, in which he has stood between you and Hunnish annihilation, encourage him, and help him to a living amidst people who may be antagonistic owing to his deformity.

If, too, any comrade comes home wholly blind, still greater is the need for you to give him a chance to live. You are not to do the silly thing in getting him a place in a School for the Blind, and to let him

earn a pitiful living, but you are to give him a chance in your daily work itself. Blind physicians can learn massage, they can diagnosticate diseases by auscultation and palpation, they can learn stenography and you can employ them in your office. You can go out of your way to urge the State to give each one of them a typewriting machine and a pension, and another gratuity for every child born after his home-coming, and last of all a newly invented machine called the optophone, by which the blind can hear the sound made by the printed letters of a book passing beneath selenium plates; in other words, they can see to read, by their sense of hearing. Talk with such a man about your cases, and many of you who rarely read your medical journals will find that they have some interest when read aloud to a blind comrade. So, too, the mere skimming over aloud of the daily paper, as only a man can skim, will help the blind. Get out your car and give him a drive, but don't sit alongside of him dumb. Tell him what you are seeing of the world through which you are motoring. Javal, the famous oculist, who lost both eyes from glaucoma in spite of operations, found great enjoyment in mounting a tricycle and being steered through the city and country, whilst he did the pedalling and the other man talked of what he saw. Blind physicians might work at X-rays, or electro-medicinal apparatus, or as apothecaries, or in repair shops of motor cars, and in using dictaphone typewriting for medical papers. Some of us ought to learn Braille or cantonnet letters for the blind, or prick points on playing cards and give a blind comrade a game of auction, off and on. Let our surgeons brighten up their skill and discover how to cure apparently hopeless blindness, just as did that bright fellow who replaced, experimentally an actually dislocated vertebra, and so restored sight to a blinded soldier. Read "June Courtenay," an English novel of 1917, and see suggestions for the blind. Why not, as an Association, join in with others, and put the essays of Osler, and Mumford into Braille or Cantonnet instead of furnishing the blind forever with stale novels and essays. It is said that telephone exchanges can be operated by the blind, who hear a telephone door drop instead of seeing a flashlight signal, and learn from the sound the number asked for. Poultry farming is novel for the blind, and let our famous Farmers' Club chip in and help out. Let the blind learn two trades, instead of one, so that if one falls dull they can keep alive on the other, such as cobbling and mat weaving, basketry and carpentry, massage and poultry raising, piano tuning and playing some musical instrument. Finally the optophone, previously mentioned, will come into use for better education of the blind and in that way open new fields for their employment. Our system of teaching modern languages, and ancient, too, is fundamentally wrong and

useless. Languages should be spoken, and not merely read, parsed and written. The blind could find a living in this way of teaching languages to say nothing of making them public benefactors.

And now as you can understand, I have condensed innumerable thoughts concerning the eyes in war into an address concerning which I want you to think most seriously. We hope that none of our comrades will meet with that misfortune of blindness which has already afflicted so many during this frightful war. If they should, here you see a few ways in which you can help them to become independent of charity. Nor are you to forget, amidst the blind, what a field is here for surgeons to discover new methods for cure, and for the philanthropists new methods of defense and prevention. Without eyes we are but the sport of fortune. With them we can work out our fate. With them, too, in these cruel days, we can look one another in the face and resolve eye to eye and hand to hand to put our backs to the wall in defense of the right to live in peace as a nation, and a shining light and example to the arrogant militants across the seas. Let us all do our share to keep them there, whilst we work out here the spirit of freedom and of democracy in the land for which we fought in the Civil War, and which we hope to maintain forever free from those detestable horrors which are, and have been, devastating the fairest lands of Europe for the past four years.

***WAR SURGERY APPLIED TO PROBLEMS OF CIVIL PRACTICE.**

By DR. CARL M. ROBINSON, Portland, Me.

The surgical problems of the battlefield, and those of military hospitals, have been, perhaps, only of passing interest to those of us who, for one reason or another, have not had the opportunity of serving in the frightful crisis through which we have just passed. It is difficult to see how the first aid methods of the front line trench, or the surgical problems of a military hospital, admitting hundreds of wounded a day, can simulate in any way the work in the hospitals of civil life. We have all rejoiced at the wonderful advance in surgery and medicine in the theater of war, and yet we have been somewhat slow in adopting such methods in our private work. We have no idea of attempting to

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cover the whole field of military surgery in this talk, but shall try to bring out just a few facts which may be of help in civil work.

The problem of the treatment of shock and the theories of its causation are still the subject of much medical literature. Traumatic shock from wounds, as treated in the army, gives us a scheme by which shock cases in general may be dealt with. Let us take a concrete example of a man with a bad compound fracture of the thigh, who is lying out in "No Man's Land". A first aid dressing is applied by his comrades or by a litter bearer of his battalion, and the man is given a liberal amount of morphia and protected from the cold if possible. Later, sometimes not until after dark, a litter squad comes to his aid. He is put carefully on a litter, which is placed on standards and covered with blankets. An oil stove or brazier is placed under the stretcher, then a Thomas splint is carefully applied and the clothing about the wound is cut away and the wound dressed. The patient is then given a hot alkaline drink, usually soda bicarbonate, and more morphia if necessary. He is surrounded with heaters and brought to the dressing station. Here he receives a hot sweet drink, such as chocolate or sweetened tea, and may receive an injection of antitetanic serum. Unless necessary his wound is not disturbed and he is transported back to a well-equipped hospital. Here, if profoundly shocked, he may be transfused or receive an intravenous injection of gum-salt solution before operation is attempted, and cardiac stimulation if necessary.

This exemplifies the chief points in the treatment of shock.

1. Morphia.
3. Heat.
4. Alkalies to combat acidosis.
5. Easily assimilated nourishment and sugars, which also help to combat acidosis.
6. Transfusion to replace lost blood, to elevate blood pressure and to stimulate.
7. Gum-salt solution intravenously when transfusion is not feasible.
8. Cardiac stimulation.

The first three need no discussion. The presence of varying degrees of acidosis in all forms of shock has long been accepted and the use of alkalies and easily assimilated sugars in the prevention and treatment of such a condition is well recognized. The experience of war surgeons the world over has proved that transfusion is the treatment par excellence of severe shock, especially when accompanied by hemorrhage.

The technique of transfusion has been so simplified that it is no longer considered a major procedure. There are many methods; but two in particular have stood the test in war hospitals. The indirect method by the use of paraffine coated tubes of the types of Kimpton or Vincent, in which the blood is drawn directly into the tube from the vein of the donor and then forced into the vein of the recipient under slight pressure, is simple and has many advantages. By the citrate method the blood of the donor is drawn into a solution of 2% sodium citrate in proportion 9 to 1, making a concentration of 2% in the resulting blood mixture. This successfully prevents clotting and the blood citrate mixture may then be injected into the vein of the recipient.

The typing of blood, which has been more or less a bugbear to those doing transfusion, has been greatly simplified, and standard sera of the types 2 and 3 may be obtained. By testing a citrate suspension of cells with these two sera, the types to which the donor and recipient belong can be easily determined. The cells of the donor must not be agglutinated by the serum of the recipient. The converse is not necessarily true. In some hospitals the blood of many patients is typed upon admission, so that donors of a given type are always available. Of the four types, Type I is called the universal recipient, as it may receive blood of all four types; Type IV is the universal donor and may give to all types; Type II may receive from Types II or IV; Type III may receive from III or IV; Type V may receive only from Type IV. If it is impossible to type the bloods in question, it is necessary simply to test the serum of the recipient and the cells of the donor. If a drop of recipient's serum and a drop of citrate suspension of donor's corpuscles is mixed on a slide and watched under a microscope, it can be determined whether agglutination will take place. If there is no agglutination the donor's blood in question is of proper type.

When blood for transfusion is not available, the use of intravenous gum-salt solution devised by Bayliss may be employed. It has the same physical properties as blood plasma, does not rapidly leave the vessels, and causes a lasting elevation of blood pressure. The solution is 6% gum acacia in 9% sodium chloride in distilled water. This solution is boiled, filtered, and then neutralized by titration with 1-10 normal NaOH. It should then be sterilized by autoclave under pressure. This solution, while simulating the physical properties of blood very closely, of course is lacking in one vital point, that is, the oxygen-carrying properties of the blood cells.

The problem of extensive wounds of the chest and lung is comparatively rare in civil practice, yet certain fundamental facts concerning

the surgery of the chest, established during the present war, will be of the greatest help to us in the treatment of many of our common chest conditions. For instance, the proper treatment of a wound which opens the chest wall, allowing a collapse of the lung, and alternately sucks in air and pushes out bloody serum, is immediate closure without drainage. Such a case will usually become a hemothorax, which may or may not become infected. Bastinelli, of Rome, and Duval, of Paris, agree that the best procedure in cases where the pleura is filled with blood is the immediate opening of the chest to secure hemostasis, to wipe out blood clots, and to assure the complete collapse of the lung. The chest wall is then closed without drainage. If serum collects, it is withdrawn by trocar.

If X-ray has shown foreign bodies in the lung, they are removed from the collapsed lung and the lung tissue repaired carefully with mattress sutures. Badly traumatized lung tissue may be excised and the lung sutured in the same manner. The important points are hemostasis, complete cleaning of the pleural cavity, and closure of wound without drainage. Serum is removed by trocar, and if lung shows tendency to expand too rapidly nitrogen is injected into the pleural cavity to keep the lung collapsed and at rest, until healing takes place. A complete collapse of the lung likewise prevents adhesions between the visceral and parietal layers of pleura.

The treatment of infected cases of hemothorax presents a problem very similar to empyema, so common in civil life. In the early part of the war the usual procedure was to open the chest and drain by resecting a rib at the bottom of the cavity. The results were comparable to resection of a rib for the usual type of empyema. Certain cases recovered very quickly, but far too many developed persistent sinuses and were essentially chronic empyemata. The cause of such a condition is the adhesions formed between the visceral and parietal pleura, or the tremendous thickening of the visceral pleura, which prevents the expansion of the lung and the obliteration of the empyema cavity. Drainage of the chest by resection of a rib and insertion of a tube, no matter what care is taken to prevent the influx of air, practically always results in a "sucking" wound and a pyo-pneumo thorax. All who have treated many cases of empyema in this way have had at least a few which have become chronic, due to the factors we have mentioned. Chronic empyemata often lead to mutilating plastic operations on the chest wall, or such radical procedures as decortication of the lung.

The drainage of infected serum which has collected in the pleural cavity and similarly early cases of empyema, are best treated by inserting a large trocar, through the lumen of which a good sized catheter

is passed. The trocar is then redrawn, leaving the catheter as drainage for the pleural cavity. The end of the catheter is placed under water or Dakin's solution. This allows pus to escape but prevents influx of air. Through the catheter the cavity is irrigated with Dakin's solution and later with formaldehyde in glycerine. Such method facilitates the early expansion of lung and the obliteration of the empyema cavity by maintaining constant negative pressure. The irrigations by Dakin's solution and the formaldehyde solution rapidly sterilize the cavity and prevent the formation of the dense adhesions and the tremendous thickening of pleura which occurs when inflammation goes on to a chronic stage. Long standing cases, in which there are large shreds of fibrin and partially organized blood clots, can rarely be successfully treated by this method.

In treatment of gunshot wounds of the abdomen, the point which perhaps impresses us the most is the frequent use of the transverse abdominal incision. This incision may be carried directly across the abdomen and well into the flanks. It at first appears mutilating, but when we consider the anatomy of the abdominal wall, we realize that the nerve supply coming from the lower intercostals and iliohypogastric and the ilioinguinal is essentially transverse. Also our blood supply, with the exception of the epigastric arteries, follows the same course. Blood given the epigastric arteries comes both from the extreme iliac and the internal mammary and if tied will not interfere with the blood supply. The rectus muscle must be cut directly across, but we remember that each segment of it has a different nerve supply, and if our incision passes through one of the tendinous interscriptions, we will interfere in no way with its function and little damage is done, even if the muscle is cut across between them. The internal and external oblique and transversalis are split when possible, but cut if necessary. This consideration of our anatomical structures justifies the use of the transverse incision when necessary, but when we consider its other advantages we find it is often the operation of choice. It gives free exposure of the viscera, which may be examined carefully *in situ*. This is a point of paramount importance. In gunshot wounds every loop of bowel must be carefully examined, and this is likewise true of many of the conditions met in civil life. We will remember the work of Crile and others, who have proved to us that careful manipulation of the bowel *per se* causes little shock, but traction on the parietal peritoneum and the mesentery causes profound shock and often collapse.

The median incision often requires the delivery of the bowel through the wound for complete examination. This drags on the mesentery and greatly aggravates shock. In the examination of the small bowel

we must bear in mind the attachment of its mesentery and pack off our loops in such a way as to prevent traction upon it. It starts at the left of the second lumbar vertebra, just where the jejunum comes out from under the transverse mesocolon, and extends obliquely down to the right sacro iliac synchondrosis. The loops of bowel thus starting with the jejunum should be folded over as examined, upward and to the right, or downward and to the left. This prevents traction on the mesentery, which we must avoid.

Just a few words about amputation and the treatment of the stump. Two points are of utmost importance to remember. First, with the modern artificial limbs practically no stumps are end bearing; in fact, it is a thing to avoid. Second—Length of stump up to a certain point is desired, to act as a leverage in the use of the artificial limb. Considering these points, we see that many of the classical operations sacrifice much tissue in order to have a well padded stump, often resulting in a stump so short that it is of little use in the control of the artificial limb. As we know, war amputations very often, on account of the virulent infections present, consist of little more than the cutting off of the grossly injured or infected tissue, making no attempt at closure. This necessitates a secondary operation for closure, after infection has been overcome. In a primary amputation two things are of greatest importance. As much skin as possible is saved, and likewise as much bone. Muscle is of less importance. We must save skin for the final closure. The advantage of leaving the bone long, is that it prevents the retraction of the muscles attached to it, which later will be of importance to us in the formation of a conical stump. A stump left in this condition often requires the removal of only a small piece of bone for the final closure, and with no removal of muscle tissue. The method of applying a sort of Buck's extension to the skin, in order to lengthen our flaps, is good only to a certain point. It does definitely prevent retraction of the skin flaps, but it is extremely doubtful if it actually lengthens them. The most approved method of treating bone in the final closure is the periosteal method. The periosteum is removed about 1 cm. above where the bone is cut across, and the marrow of the bone for about the same distance is curetted away. This leaves us the end of the bone free from periosteum and marrow and will give us a rounded end to our stump from the gradual absorption of some of the bone tissue, and prevents the formation of bone spicules from shreds of periosteum, which may result in a painful stump. An important point to remember that a satisfactory stump is one in which the scar of the skin suture is not adherent to the bone. The protection of the end of bone by muscle flap is not necessary.

Necrology.

ALBERT HENRY BURROUGHS

After an impressive career in medicine in Westbrook, as a staunch practitioner of the healing art, and at one time a very active member of the Maine Medical Association and of the Cumberland County Medical Society, Dr. Burroughs died suddenly from apoplexy September 10, 1918. He had not been strong since the previous autumn, when he contracted a chronic bronchitis from exposure, but he had kept at work as usual, and was reading an article "On Aneurism," concerning a patient of his own, a short time before his final seizure, which lasted but a few hours until his death.

He was born in Houlton, Me., the son of James and Eliza Smith Burroughs, October 16, 1842, removed in a few years to Buckfield in the same State and after an ordinary school education he enlisted in 1861, at the early age of 19, in the Civil War. He was at first a private, but as orderly sergeant he was seriously wounded at the Battle of Antietam in September, 1862. He protested in the hospital so strongly against a proposed amputation that he saved his wounded leg for good walking service during the rest of his long and active life.

Returning to civil life he became an expert cabinet maker in Boston, being a skillful carver for one thing, until after losing the index finger of his left hand he decided to take up some less dangerous occupation. He then settled in Portland, as an expert accountant, until about 1875, when his mind was turned toward medicine from acting as nurse to a decrepit uncle. The physician in charge said that he would do well in medicine, so he studied at the Portland School for Medical Instruction and obtained his degree of doctor of medicine at the Bowdoin Medical School in 1878. He settled at once in Westbrook, and had practised there nearly forty years at the time of his death.

Dr. Burroughs was distinctly a practitioner of medicine. Not that he did not love surgery, but he regretted that, owing to the injury to his left hand, he could not properly use the surgical instruments needed for modern work with satisfaction to his high ideals of what operations ought to be.

Dr. Burroughs was twice married; first to Miss Fannie Gerrish, who died in 1907, and second, to Miss Adeline Ray, of Westbrook, who survives.

The finest epitaph concerning the career of Dr. Burroughs is this: He never discouraged a patient.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

AN IMPERATIVE NATIONAL DUTY FOR PHYSICIANS.

The war is apparently done with, but people think, however, that for years to come Germany will have to be policed with soldiers just as Germany policed France for more than two years after the peace of 1872. This is necessary in order to obtain indemnities. In order to carry out this work, which is wearisome to the soldiers in times of peace, this nation will have to do her share. We still have our Mexican problem, our differences with Japan along the Pacific coast, and now we must face a great industrial unrest during the period of demobilization and readjustment of our economic forces.

The national need now, in which the medical profession ought to be intensely interested, is a system of compulsory drilling of our young men, so that in time of need we shall have some central force around which to rally.

It is the duty of every physician to recognize the dangers, to speak in public to every friend and acquaintance, and at every meeting of citizens and physicians, of two items of national importance not for a moment to be underestimated, physical examination of all the students in high schools, colleges and academies, and compulsory military training.

DETECTION OF THE FEEBLE-MINDED.

Bearing in mind the value to the State of the early detection of the feeble-minded, Berry and Porteous, in Melbourne, have been studying this topic and had made a preliminary report in the *Medical Journal of Australia*, in August, 1918. Their suggestion is that the determination of the prevalence and degree of mental defects should be based on measurements of the cranial capacity. Those who fall short of, or greatly exceed, the averages of their sex and age should be subjected later to the various intelligence tests at present utilized in modern psychology. Thus, for instance, 50 per cent. of the microcephalics were found to be below average intelligence and only 5 per cent. above that average. But if the skulls were macrocephalic the subnormal only showed a percentage of 14 per cent., and the average above the normal intelligence was 25 per cent. Environment may be of value in these studies, but careful study of the feeble-minded from this suggested point of view commends itself to the intelligence of the profession as a whole, and in particular of those who are especially interested in this class, which to a certain degree threatens the nation in many ways, particularly by inheritance and defect transmission by marriage, of those below the average.

THE CURSE OF IMMOBILIZATION.

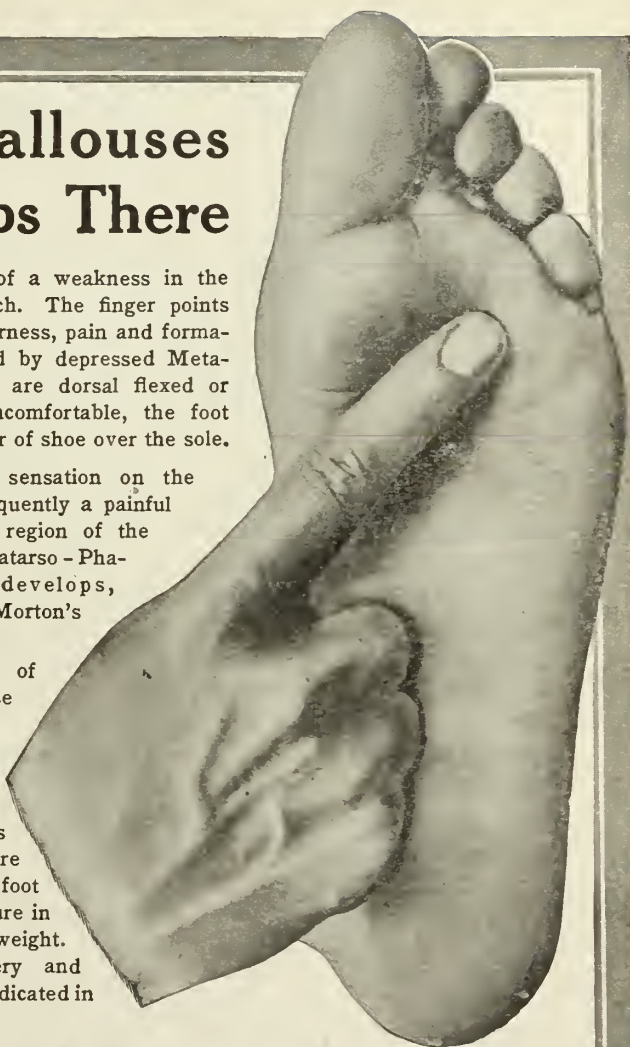
Under this title Dowden writes a brief but powerfully expressed paper on the disadvantages, dangers and disabling results of immobilization of fractures, not only in war, but in civil practice. He urges that from the very beginning active movements and passive should be carried on, steadily increasing in range, extent and amount, and that splints should never be used except when absolutely necessary, and then only for a short time. This dogma refers largely to fractures of the upper extremity, but does not by any means exclude the lower. If demand is made on nature without pain, nature will generally respond. Pain is the danger signal in passive or active movements, and when it appears these should be greatly modified and reduced in frequency and in length of time employed. Too familiar to us all are instances of crippled men about our streets who never again will touch toes to the ground because an injured, fractured joint was immobilized for weeks, and all movements absolutely prohibited until permanent cicatricial adhesions had formed. Upon these cases the natural bone setters set up their valuable trade of early passive motions of all fractures. The war has, in Dowden's opinion, done nothing greater

Pains, Callouses or Cramps There

are a usual indication of a weakness in the Anterior Transverse Arch. The finger points out the location of tenderness, pain and formation of callosities caused by depressed Metatarsal heads. The toes are dorsal flexed or cramped, shoes feel uncomfortable, the foot widens and spreads upper of shoe over the sole.

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Dr Scholl's *Corrective Foot Appliances*

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for us in the way of instruction than that the over use of splints is a dangerous thing in every fracture. "Down with the curse of immobilization," is the cry of Dowden.

DANGERS OF UTERINE CURETTAGE.

Dilating and curetting is so much a part of the almost daily work of the gynæcologist that he probably never thinks of its possible dangers. For that reason we commend to our readers careful attention to a paper on this topic in the December number of the *Annals of Surgery*, by Lincoln. Starting out with a history of the operation as introduced by Recamier about 1845, he follows its development into a thoughtless fashion, for every case for which the surgeon can balm his soul toward a fee for an operation. He then builds a very instructive paper, based on forty-three recent Canadian operations with eleven deaths, say a mortality of 25 per cent. These are tabulated in brief, though significant form, under "Cases of Hemorrhage Following the Curetting;" "Cases of Sepsis;" "Cases of Uterine Rupture;" "Cases in Pernicious Vomiting," and in primiparæ. These instances deserve careful thought and study, and we commend to our readers the idea that a very practical paper on this topic might well be prepared by some surgeon willing to tell exactly what his experiences with curetting have been, read before the meeting of our Association, discussed and finally printed in our JOURNAL. Any operation with 25 per cent. of deaths deserves, we are sure, most careful study of cases proper to operate upon and improvement in methods of operating or instruments with which the operation is to be performed.

FOREIGN BODIES IN THE EYE UNDER THE ACCIDENT INSURANCE LAWS.

Champlin makes the suggestion that every physician removing any foreign body from the conjunctiva or cornea shall be careful in the interests of the laws for accident insurance to note particularly the vision of the eye at the time of the office visit, for many men simply injured often claim unjustifiable damage to the sight from the temporary lodgment of a bit of steel or emery, for instance, in the cornea, yet far from the centre of the pupil where it might, if infected, affect the sight.

SIMULATION OF MUMPS.

Mention has been made from time to time of the simulation of various diseases and injuries amongst soldiers in order to avoid active service. The latest disease to be successfully simulated is the mumps. By pinching the nose, closing the mouth, and distending the cheeks, air can be blown into the parotids and mumps be thus simulated. If the surgeon suspects such an attempt at fraud, the way to make sure of it is to use lumbar puncture and assure oneself of lymphocytosis of the cerebrospinal fluid. Moreover, if nothing is found, the mere repetition of the operation generally brings the malingerer to his senses.

MEDICAL NOTES.

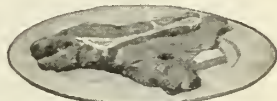
EFFECT OF GROUND GLASS UPON DOGS.

Incited by the German propaganda of filling bread, cakes, doughnuts, pies and canned material for food with ground glass, there was much anxious talk and much outburst of aggravated excitement amongst a certain part of our population. Everything in cans, every bit of food, was carefully tested with teeth and tongue before being swallowed, for fear that it might cut the internal vitals to pieces. Simmons and Glan, both of the M. R. C., at Fort Sam Houston, experimented with ground glass on dogs, feeding it to them for several days with their daily meat rations. Out of ten young dogs thus tested, and later killed under chloroform, careful investigation showed that the ingestion of ground glass produces no lesions, gross or microscopic, within the gastrointestinal tract of dogs.

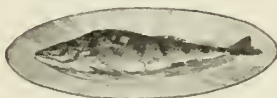
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(3010)

A PREVENTION OF TENDON ADHESIONS.

Fenwick prevents adhesions of the tendons after injuries to the hand by passing catgut tendons under and over the tendons as far down as the annular ligament before applying the final sutures to the incision and original wound opening, if occurring in war.

CHRONIC VASOCONSTRICTOR SPOTS AND THEIR MEANING.

The current number of the *Boston Medical and Surgical Journal*, Jan 2, 1919, has a good paper by Tracy on this topic, under which he means those curious whitish spots occasionally seen upon the skin of almost any part of the body. Several cases of this sort are mentioned in detail, and illustrations appended. The conclusions which the writer draws are that these are invariably associated with nerve and brain lesions and are often accompanied with neighboring pigment spots. They imply increased flow of nervous stimuli over the vasoconstrictors in the region involved. All of these spots, in cases in which peripheral and cord lesions can be excluded, point to an organic brain lesion. The paper is well worth hunting up and reading in completeness.

We also commend to our readers, and particularly to students and younger practitioners of medicine, a very valuable set of charts concerning renal diseases, by Jelalian, in this same number. The charts are comprehensive enough to show the pathological conditions both of the kidney and its excretions. The author has omitted all suggestions for treatment upon the chart, believing that it would be dangerous ground upon which to tread.

NOTICE.

The Council of National Defense authorizes the following:

Early in February each physician in the United States, exclusive of those who served in the Medical Corps of the Army for the past two years and members of the Volunteer Medical Service Corps, received a communication from the Council of National Defense, requesting that he fill out and return promptly to the Washington office an accompanying questionnaire, so that there may be on file in Washington complete individual information covering the members of the profession. Simultaneously with the distribution of these questionnaires, state and county representatives of the Volunteer Medical Service Corps were instructed to urge all doctors in their communities to comply promptly with the request of the Council to fill out and forward promptly to Washington the blanks sent them, and to advise those who by any chance failed to receive blanks to communicate with the

Council of National Defense at once in order that application blanks might be furnished them.

The Volunteer Medical Service Corps was organized early in 1918 to serve the government during the emergency of war. As this emergency has ceased to exist, active membership in the Corps is no longer solicited. However, the survey initiated by this organization last year has proved of such value as a source of information concerning the individual members of the medical profession that the Surgeons General of the Army, Navy and Public Health Service have requested the Council of National Defense to complete it so as to include every doctor in the country, in order that a permanent record of the profession may at all times be available for reference in future emergencies. Upon their completion, the records will be transferred to the Surgeon General's Library, where they will be kept up to date by a force assigned for the purpose, and be accessible to all government bureaus.

Every physician is requested to cooperate with the Council of National Defense in making this record complete by returning at once the questionnaire received or by writing to the Medical Section of the Council of National Defense, Washington, D. C., and requesting that a blank be sent him if through an oversight he did not receive one.

THE HARRISON ACT,

AS AMENDED by the new War Revenue Act, will be mailed postpaid to any physician who will send a postal request therefor to "Mailing Department, Parke, Davis & Co., Detroit, Mich." Please observe directions strictly.



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(3005)

County News and Notes.

YORK.

YORK COUNTY DAUGHTERS OF HYGIEIA.

The annual meeting of the York County Daughters of Hygieia was held at Hotel Thatcher, Biddeford, Thursday, January 2nd.

After dinner the business meeting was called to order by the Vice-President, Mrs. C. F. Kendall. Mrs. C. E. Cook, South Berwick, the President, was unable to be present.

Mrs. R. S. Gove, of Sanford, brought before the ladies the question of the adoption of a French orphan. After an interesting discussion it was voted to adopt a baby girl.

The officers for the year 1919 were then elected:

President—Mrs. C. F. Kendall, Biddeford.

Vice-President—Mrs. F. W. Smith, York.

Treasurer—Mrs. W. W. Smith, Ogunquit.

Auditor—Mrs. C. E. Thompson, Saco.

Mrs. Kendall appointed Mrs. D. E. Dolloff as Secretary. The committees will be announced at the April meeting.

Those present were: Mrs. H. L. Prescott, Kennebunkport; Mrs. R. S. Gove, Sanford; Mrs. W. W. Smith, Ogunquit; Mrs. F. C. Lord, Saco; Mrs. C. E. Thompson, Saco; Mrs. C. F. Kendall, Mrs. D. E. Dolloff, Biddeford.

MRS. D. E. DOLLOFF,
Secretary pro tem.

Personal News and Notes.

Major Wm. L. Cousins has returned home, and for the time being is located at St. Barnabas Hospital.

Capt. Edson S. Cummings, formerly of Lewiston, has moved to Portland and will devote his time exclusively to X-ray work.

We are very glad to welcome home Capt. A. H. Little, M. C., of Portland, after active service overseas. His experience, differing from those of all of our other members, will be welcome to the members of the Association at the annual meeting and be read with pleasure in the JOURNAL later on.

Constipation

THE exhaustive investigation of the therapeutic properties of FLEISCHMANN'S COMPRESSED YEAST, conducted at Jefferson Medical College, the Philadelphia General Hospital and the New York Roosevelt Hospital by Philip B. Hawk, Ph. D., and associated physicians, demonstrates the value of yeast in the control and cure of constipation.

Ten cases were treated. Several were chronic and of years duration. Nine were controlled or cured, movements remaining regular after yeast was discontinued.

The tenth case, complicated with subacute appendicitis and high intestinal stasis, showed no improvement.

Dr. Hawk's report (Journal A. M. A. Vol. LXIX, No. 15), says :

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We have received from our fellow member, Dr. C. B. Witherle, in Florence, a most delightful poster showing Italy exulting over the end of the war and the taking of Trieste. Over in Italy they always illustrate their posters with the national hymn and a pianoforte score, which adds to the pleasure of seeing a beautiful picture the delight of having a chance to play the music of the words attached to the fine sketch above.

Capt. L. L. Powell, M. C., of Saco, has been mistakenly reported in the JOURNAL as in training in various southern base hospitals. The real facts are that he was transferred from the Milliken Regiment to the 101st Infantry a year ago last summer, and at once went overseas. He was later transferred to the 101st Machine Gun Battalion. He now has two service stripes, has been cited for meritorious service under fire, and is now located at the Northeastern Headquarters in Boston.

The JOURNAL has received a very agreeable letter from Capt. C. B. Sylvester, M. R. C., U. S. A., President of the Cumberland County Medical Society, at present attached to a base hospital at Markleton, Penn. He writes concerning influenza and tuberculosis immunity, and encloses a curious snapshot of a negro soldier, 6 feet, 8½ inches high, who is holding out his left arm, under which stands, all clear, another soldier measuring 4 feet, 11 inches in height. Capt. Sylvester gives us no clue to the date when he will return to the office which he is so well fitted to occupy amongst us.

Delightful letters have just been received from Capt. S. E. Fisher, M. C., of Portland, now serving at the aviation camp in Fort Sill, Oklahoma, and from Lieut. Thomas A. Foster, M. C., of Portland, now in France. Let us hope that both of them will be present at the June meeting of the Association and enrich the members with heart-to-heart talks on their war adventures. We have also received from Lieut. F. E. Rowe, M. C., and at present attached to the American Expeditionary Forces in France, a most delightful letter, in which, amongst other items of interest to Maine, we note that in the same base hospital with himself is our excellent Capt. R. B. Swift, of Portland. Dr. Rowe will be remembered by us for his brilliant paper against "Health Insurance in Maine," read before our Association in June and printed in full in a former number of the JOURNAL. Lieut. Rowe has plenty to do in his hospital, but believes that under present rulings his adventures should be suppressed. With his positive enthusiasm for a scrap with the pushers of health insurance, he regrets that he is not on hand to take part in the fight against this pernicious ideal. We can assure him that legislation has been postponed for the

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present Legislature, as was recommended by the last President of the Association at the 1918 June meeting. It is rare for any physician in Maine to receive in a single week three such capital and satisfactory letters as the writer has had the pleasure of receiving, reading and answering on the spot from Rowe, Fisher and "Tom" Foster.

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Dr. ADAM P. LEIGHTON, JR., *The American Journal of Obstetrics and Diseases of Women and Children*, November, 1915, page 878.

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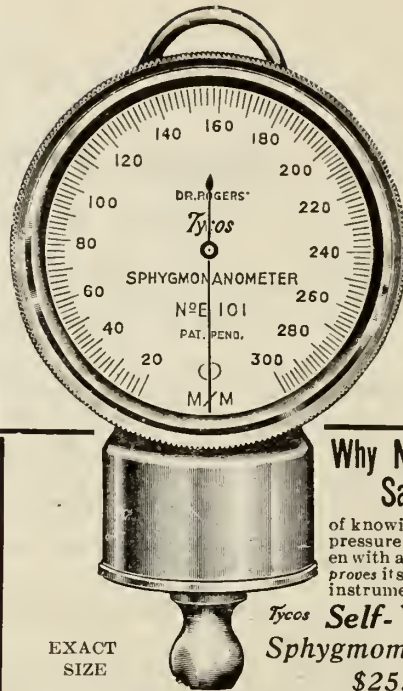
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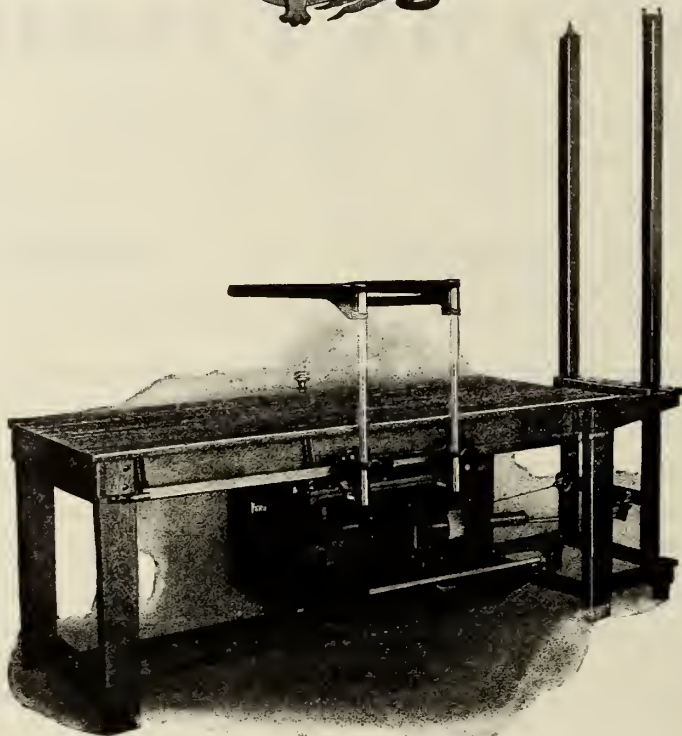
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OF THE

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VOL. IX.

APRIL, 1919.

No. 8

*STATE CARE OF THE TUBERCULOUS.

By T. E. HARDY, M. D., Waterville, Me.

Previous to October 1, 1915, the care of persons sick with tuberculosis in the State of Maine was left almost entirely to the individual. There had existed for several years a State Anti-Tuberculosis Association, with subordinate societies in several counties. The function of this society, however, was almost entirely educational. There were two sanatoriums supported by private charity with the aid of small appropriations from the State treasury. These institutions together were caring for eighty-four patients when taken over by the State. These patients were drawn very largely from the well-to-do class of people. There was practically no provision for the very poor, among whom, as is well known, tuberculosis is most prevalent.

During the past two years and a half we have seen a great change; where there were less than one hundred people under treatment then there are now over two hundred and twenty-five. The former patients were so fortunate financially as to have been able to provide treatment for themselves without the assistance of the State. The present patients are very largely drawn from the less fortunate, yet just as deserving class, for whom proper treatment would be impossible unless provided by the State. Previous to 1915, only those cases which were curable were accepted; now all cases, regardless of their condition, are received. In the development of so great an under-

* Read before the 1918 session of the Maine Medical Association.

taking, in which the need of rapid expansion is so urgent, many exacting problems are constantly presenting themselves. To properly carry out the work and keep apace with the needs a very definite policy must be established. We must consider carefully the whole tuberculosis situation, must anticipate any conditions that may arise and formulate sane plans for meeting these conditions.

During the short period of State control there have been over one thousand applications for admission. These applications have come from every section of the State and from all conditions of society. An attempt has been made to care for all patients, whatever their age or how advanced the disease might be. The only applications which have been rejected have been those from persons suffering from surgical tuberculosis or from a few with complications which we were not properly equipped to care for. Many times the waiting list has been so long that applicants have become discouraged and refused treatment when we could accept them. It has frequently happened that during the long wait for admission the disease has progressed so rapidly that the attending physicians have felt it unwise for the patients to accept treatment. Several times patients have been sent without making application, and we have either had to make arrangements for them outside of the institution or turn them away.

The commission in charge of the sanatoriums has been trying to formulate a workable plan to meet the needs effectively and well. We are not concerning ourselves with the educational problems. This work will be well cared for by the State Department of Health and the State Anti-Tuberculosis Society. We are simply trying to provide for the State of Maine an efficient and complete equipment for the treatment of the disease, and to bring the family physician and the public in general into close touch with the work. We have tried to keep the family physician thoroughly informed of the progress of his patient while under treatment. We are now and have been for some time, sending a report of his condition on admission. Every two months we send out a temperature, pulse and weight record, together with a chart of every re-examination. Since we have put this plan into effect we have been very much impressed by the improvement in the class of cases sent in and feel that these reports may have had not a little influence in bringing about this improvement. We purposely do not send reports on the laboratory findings for the reason that their relative value has been and is evidently misunderstood.

At the receiving office we are constantly receiving letters from physicians saying that tuberculosis has been suspected in a given case for a long time and that they have hesitated about urging treatment

until their suspicions were confirmed by positive sputum findings. Such an occurrence is unfortunate. Many cases, while waiting for a positive laboratory report, have advanced from an early and curable stage to a far advanced and hopeless condition. As a matter of fact, only about forty per cent. of all cases admitted during the past two years have had a positive sputum. This includes all classes of cases, therefore we have felt it was not wise to make mention of laboratory findings in these reports. Practically the only value of routine sputum examination is the help that it may give in making the decision in regard to the discharge of a patient. If all signs of activity have disappeared we would still hesitate in advising the discharge of a patient if the sputum contained bacilli, because of the danger to his associates.

Besides keeping the physicians and friends in touch with the patient's progress we are trying at the receiving office to gather information which may be of value to the health department. We have a spot map, showing the location of each case. We also have a record of the number of people coming in contact with a patient before admission to the sanatorium. This information is forwarded to the health department, and as that department becomes better organized will be used by them in carrying out their work of prevention. We also keep a record of each patient's financial condition.

Regarding the future plans of the Board of Trustees, permit me to outline briefly what we hope to do. At the present time we have two institutions, the Western Maine Sanatorium, at Hebron, and the Central Maine, at Fairfield. There is now an appropriation available for a third institution in Aroostook County, to be known as the Northern Maine Sanatorium. Construction will begin there this season. These institutions can readily be enlarged to care for 250 people each. As it is probable that eventually at least 1,000 beds will be needed in the State there will undoubtedly be a fourth institution, located in Penobscot County, to be known as the Eastern Maine Sanatorium. Four such institutions, we believe, will give us sufficient strictly sanatorium capacity to effectually deal with any situation that may develop.

It is not meant that these institutions will care for all cases of tuberculosis needing treatment in this State, but rather to provide for all those cases in which the probability of improvement is good. There will still be a very large number of cases to be provided for, and the best arrangement for these cases is perhaps the largest problem we have to meet. Some States, notably Massachusetts, have adopted the plan of county sanatoriums, to care for advanced cases and meet emergencies. In these institutions patients awaiting admission to the State institutions are cared for and an opportunity is given for their observa-

tion. They receive emergency cases as well as advanced cases, which are always best treated near their homes. Such a plan is very expensive, and while admirably meeting the needs in Massachusetts, might not be entirely satisfactory in a rural community such as ours. Some States care for all their tuberculous in large sanatoriums having a capacity of 3,000 or 4,000 patients. This plan is adopted on the theory that the average per capita cost can be reduced to the lowest possible figure in this way. Experience has shown, however, that this is not true, nor is the plan practical. Those most familiar with sanatorium management are of the opinion that institutions with a capacity of two hundred or three hundred patients are the most economical and the most satisfactory to maintain. The tuberculosis commissions in some States, particularly in the State of Connecticut, are advocating the care of tuberculous patients in connection with general hospitals. It appears that this policy might well be adopted in the State of Maine. We are aware that very great objections might and probably will be advanced in opposition to such a plan. Are such objections well founded? Is advanced tuberculosis a more dangerous disease to treat in a general hospital than are many other diseases which are accepted without hesitation? It is certainly no more contagious than pneumonia or typhoid. With proper precautions it can be treated with absolute safety. The only argument of real weight in opposition to such an arrangement is the length of time these cases are under treatment. This argument will not hold if special pavilions are provided, as has been suggested. On the other hand, there are many advantages in this arrangement that by far outweigh the objections. There are without doubt more than fourteen thousand people with active tuberculosis in Maine. What other disease of equal incidence is so poorly managed by the medical profession? Appendicitis, gall bladder disease, etc., are readily recognized in all sections of the State almost before they happen. It is the exception rather than the rule if proper treatment is not carried out at once or at least advised by the physician. Tuberculosis, however, is missed time and time again. It repeatedly happens that the very best men in our profession are allowing active tuberculosis to get by without recognition, and if by good luck a profuse hæmorrhage or some similar accident attracts their attention to the real condition they are almost sure to advise poor treatment. Men are constantly advising their patients to go to the back woods, to exercise in the open, practice breathing exercises, when as a matter of fact the only cure for tuberculosis known to-day is rest. The fact that an occasional patient gets well in spite of the treatment advised serves to keep such fool methods in use.

Now, why is it that trained men, keen and efficient in the management of many diseases, utterly fail in the recognition and management of tuberculosis? I believe that the chief reason is because tuberculous patients are barred from the general hospitals so that the members of the hospital staff, the interns, medical teachers and instructors have little or no knowledge of what tuberculosis is. If we in this State adopt the policy of treating tuberculosis in general hospitals, where it can be properly taught and studied and put on the same footing with other maladies, it will be just as readily recognized and just as efficiently treated as other maladies. If we confine the treatment of any disease to special institutions, only those men connected with such institutions will be proficient in its care. What has been said in regard to the medical profession applies also to nurses. Very few nurses, even if they can be persuaded to care for patients sick with tuberculosis, are really competent to do so, for the reason they have had no opportunity in their training to become familiar with tuberculosis. In this State, where the population is so scattered, county hospitals would seem impracticable. Tuberculosis pavilions in connection with general hospitals would thus be the only way that advanced cases could be treated near their homes. Such cases are ill suited for the rather vigorous treatment carried out in the sanatoriums, nor is curative treatment worth while. It is far better to keep these very sick people comfortable near their homes, where they may see their friends frequently and yet not be a burden or source of danger to them. With a tubercular pavilion in connection with the general hospitals we shall be provided with means to properly care for emergencies. The frequency of tuberculosis becoming active during pregnancy is rather alarming. Records show that repeated pregnancies are a serious factor in the prevalence of the disease. It is a problem we must meet. To properly treat such cases in large sanatoriums is evidently impracticable. At the present time we have to either refuse admission to these cases absolutely, or, if we accept them, send them away before delivery is expected. We have already had enough of these patients to impress us with the importance of immediate action. Is not a tuberculosis pavilion in connection with your general hospitals the ideal method of meeting this need?

The treatment of tuberculous children is another problem. This feature of the work has been the most important and the most satisfactory we have undertaken. At the present time we have over forty patients of school age, nearly twenty per cent. of all cases under treatment. We have conducted an open air school during the spring and fall months, but have been unable to do so during the coldest weather

for lack of a suitable building. It is evident that caring for these boys and girls in close association with adults is extremely difficult. We trust that the next Legislature will provide us with funds for a suitable building at the Central Maine Sanatorium and thus put this feature of our work on a firmer basis. We have in mind a separate dormitory and an open air school room, play room and workshop where manual training, domestic science, etc., may be taught. If possible, a separate dining room will be provided, as the influence of adult patients in a state institution upon children is not always good. We feel that even with the limited resources we have had to do with thus far the work accomplished for these children has been well worth while. Several children have kept up with their grades and received their regular promotion when they returned to their own schools. One patient while under treatment kept up her grade in one of our largest preparatory schools and is now going along with her class.

We receive many applications for the treatment of surgical tuberculosis, for which we have no provision. There should certainly be one institution in this State properly equipped for treatment of this disease and we hope soon to be able to make such provision. We feel that very little will be accomplished toward ridding our State of tuberculosis unless we provide properly for dealing with it in all its manifestation and under all conditions.

Another important problem until now not even considered in Maine, and in fact, in hardly any state institution that I know of, namely, what to do with these patients when the disease has become quiescent or arrested. At the present time, when all evidences of activity have disappeared the patients are discharged to return to their homes. As soon as a patient's condition warrants it, he is started in a trade or vocation that appeals to him and which is best suited to his condition. He is gradually worked along until thoroughly trained in this vocation and thus able to maintain himself. While the training is in progress he is constantly under the observation of a physician, as these institutions are a part of the sanatorium. When he is discharged he has a means of livelihood suited to his physical condition, he knows from actual experience just how much he can do, just what precautions he must take, and with this knowledge ought to go on indefinitely. We hope that we may soon be able to use these methods here in Maine. Its importance cannot be overestimated. It is not enough to cure a patient who is sick with tuberculosis; we must start him entirely anew. If we send him back to the same conditions in which his trouble developed we are almost sure to see a return of his trouble. Besides, if this plan is put into

operation it will help to overcome, to some extent at least, one of the unsatisfactory influences of present sanatorium treatment. We are frequently impressed with the evident loss of ambition and self reliance that comes over the inmates of our institutions. The nature of the treatment is responsible for it. Idleness is taught to the highest degree. Patients are waited on and coddled, too, for long periods. They are even encouraged not to breathe more than is necessary to actually maintain life. They lie in bed for long periods and must of necessity develop lazy, indolent ways. Vocational training in connection with sanatoriums would to a great extent overcome this and be worth consideration on this ground alone, even if there were no other reason for its introduction. If it is worth while for the State of Maine to undertake the care and treatment of tubercular patients, it is worth doing well. While vital statistics may show a slight falling off in the death rate from this disease as a result of the work already done, it is but a small improvement. The real campaign is just beginning.

In this brief paper we have only considered the subject from the purely treatment point of view. The most important factor in anti-tuberculosis work I have not mentioned at all, namely its early recognition. This is strictly up to the men of our profession. When we city and country doctors become as keen in recognizing tuberculosis in its incipiency as we are in recognizing other diseases which are no more prevalent, tuberculosis will very rapidly disappear. Already we have seen a great improvement. The demand for sanatorium beds is constantly greater. Let me assure you that the commission in charge of this work will make every effort to meet the demand.

THE PROBLEM OF TUBERCULOSIS IN CHILDHOOD.

By HENRY D. CHADWICK, M. D.,
Superintendent Westfield State Sanatorium.

This is too large a subject to cover in a short paper, therefore I shall only attempt to write about some of the most important features of the disease as manifested in children between the ages of four to sixteen years of age.

Only a few years ago pulmonary tuberculosis in children was considered a rare disease and little if any provision was made for such

patients in public sanatoria. The Westfield State Sanatorium was built in 1910 for adult patients. The first patient admitted happened to be a child seven years old. Each succeeding year the number has increased until a ward with eighty beds especially designed for children was erected in 1914. This was soon filled, and two pavilions intended for adults have since been given up to children, and they are now crowding out the men and women from the two remaining wards. Altogether the institution now has one hundred and seventy children and ninety-five adults. All the children that apply for admission to a State sanatorium in Massachusetts are sent to Westfield. By segregating them in one institution they can have school privileges and special buildings adapted to their care. I think the time will soon come when the Westfield State Sanatorium will be an institution devoted entirely to the care of children.

Tuberculosis affects mankind differently according to the age period. In infancy it is a generalized disease; in childhood it assumes a glandular type, and in adult life the pulmonary is the usual form. Adult tuberculosis is but a later stage of the glandular and peribronchial disease in children. Tuberculosis, therefore, should be considered one of the common diseases in childhood and suspected in every child that seems debilitated or has obscure symptoms.

To understand why we have these distinct types it is necessary to consider how the body reacts to infection at the different age periods. An infant infected with tubercle bacilli develops general miliary disease and meningitis. The tissues have not acquired as yet the power to react when invaded by the bacillus and therefore tubercle does not tend to localize. In childhood, however, the ability to react to infection has developed and localization of the bacillus occurs most often in the lymphatic glands or more rarely in the bones. As the result of this reaction tubercle first forms in the invaded glands. We have then a stage of infection, and whether this develops into disease depends upon many factors. This power of reaction, or as we often term it, resistance, varies with different individuals and with different races. When the reaction is sufficient fibrous tissue develops about the tubercle and encloses the bacilli so completely that they are imprisoned and can do no harm as long as the wall remains intact. If, however, the child's vitality is lowered by unhealthy living conditions or by an intercurrent disease, more often when of an inflammatory type like pneumonia, measles or influenza, the resistance is overcome with the result that the wall of the tubercle is softened, the bacilli are released, and the disease spreads to adjacent tissue. That is the pathological condition when pulmonary tuberculosis, the disease, develops.

I want to emphasize the difference between infection and disease. Nearly all children before they reach sixteen years of age have at some time taken into their bodies tubercle bacilli, either through the air or food, that is, they have become infected and are potentially tuberculous. In a great majority of children the tubercle remains latent throughout life, although the child is sensitized and reacts to the tuberculin test. If, however, the infection is awakened into activity by one of the causes mentioned above symptoms appear and then we have clinical disease.

The early symptoms of tuberculosis as exhibited in childhood are somewhat different from those we consider characteristic in later life. Children are less apt to complain and tell us of their bad feelings. Their first symptoms are subjective and it is only by close observation that these symptoms are discovered. These are also more transient and may be masked by more noticeable conditions such as earache, enlarged tonsils, adenoids, skin eruptions or eye diseases. In any ailing child where diagnosis is not clear tuberculosis should always be considered either as the primary cause of obscure symptoms or as a smoldering secondary condition.

In taking a history of a child, if it is found that there was intimate or prolonged exposure to an active case of pulmonary tuberculosis it is almost certain that that particular child is infected—not necessarily diseased, but there has been implanted a focus which, if the environment is not good or the child does not have sufficient nourishment or becomes debilitated from other disease, will be almost certain sooner or later to cause signs and symptoms of tuberculosis.

Do not, however, expect to find a positive family history to account for every tuberculous child, because in 34 per cent. of two hundred of our cases no direct exposure to a recognized consumptive was acknowledged. Our investigation shows that a tuberculous mother was more apt to infect a child than was the father; a diseased sister is more dangerous to a sister than to a brother; and a brother is more likely to infect his brother than his sister. The more intimate the association in childhood the more certain it is that infection will follow, and it is to be assumed that where exposure is both intimate and prolonged that the number of bacilli taken into the child's body is greater, and therefore where such is the case the disease is most likely to follow infection.

Symptoms vary with the location of the tubercle and also with the amount of local reaction set up by the presence of the bacilli. If the local reaction is marked the tubercle soon becomes incapsulated in fibrous tissue and no general systemic disturbance is evident. Occa-

sionally, however, an individual has very little if any immunity or power to react to infection. Such a person might be said to have a pacifist constitution. When invaded by the enemy they offer no resistance to its presence and allow the invader to spread with such rapidity that death occurs within a few weeks. They have a fulminating type of tuberculosis. The usual form, however, runs a chronic course due to an inherited or acquired relative immunity. In these cases fibrosis occurs in the tuberculous area and the disease tends to become quiescent or arrested.

Infection in nearly all children is first localized in the bronchial glands and about the root of the lung. If disease develops from this infection the glands at the hilus enlarge and become congested and absorption of bacillary products takes place from the active tubercle. The immediate results on the child will be listlessness, undue fatigue, lack of appetite, and if the temperature is taken in the late afternoon it would be found one-half to one degree above normal. The child may exhibit nervous irritability or seem dull in school. A small loss of weight may occur, but first there will be a considerable period when the child will fail to develop normally either in height or weight. When enough peribronchial irritation develops, either from inflammation or pressure, cough will begin. Ill defined and vague transitory pains in legs and body may be complained of, which are caused by the toxemia. These symptoms are the most early manifestations of the disease in childhood, and when they occur a thorough physical examination is demanded. The examination should be complete and not confined to the chest. The symptoms which I have mentioned other than cough might be due to various conditions in which there is toxemia or to tuberculous disease elsewhere than in the lungs. The tonsils or adenoid tissues may be diseased, the teeth carious, adenitis of the cervical region, axilla or groin, mesenteric or peritoneal tuberculosis may be present. Other infection must be considered and excluded.

In the early stage of bronchial gland disease the physical signs will show impaired resonance confined to the interscapular region only. There is no characteristic change in the breath sounds, no rales are to be heard. The whispered voice may be clearly heard below the spine of the seventh cervicle vertebra—the De Spine sign. If the disease advances it involves the adjacent peribronchial pulmonary tissue, and then radiates toward the apices and usually extends to both. Percussion at this stage not only shows dullness between the scapulæ, but this extends upward into the supraspinous fossæ. The next advance invades the anterior part of the apices as shown by dullness above the clavicles. Even when percussion shows marked consolidation it is

uncommon to hear rales in these children until they have advanced lesions. The tendency of the disease at this age period is to remain peribronchial and of a fibroid type. Radiographs may show the diseased bronchial glands to be enlarged on one side of the root of the lung more than on the other, but the infection is almost always bilateral and the radiating shadows showing extension of the disease along the bronchi extend to both apices in most cases. In advanced disease, when the pulmonary tissue is involved and when rales and bacilli appear, the signs and symptoms are like those found in an adult.

The bronchial gland and peribronchial stage of disease is very different in its manifestations. This period is the true incipient stage of pulmonary tuberculosis. The symptoms of childhood tuberculosis in the early stage are those of a toxemia resulting from tuberculous absorption. Cough may be entirely absent and no signs or symptoms indicating the focus of disease may be present. The disease is a relapsing one in its characteristic. The symptoms of fever and fatigue depend upon the activity of the child. When the diseased child is not exerting himself the symptoms are in abeyance. A little over fatigue by too much play or lack of sleep will cause a prompt return. Such a child has no reserve strength and if in school is apt to be looked upon as lacking in ambition or is called lazy. They lack strength to keep up continued mental or physical work for long at a time. They can neither work or play as normal children. When a child with that history comes to your notice you will find in most instances evidence of bronchial gland tuberculosis or may be of more advanced disease if you look for the physical signs I have described. It requires considerable experience and the constant practice of percussion to keep the ear trained to detect the early changes.

I would emphasize also the fact that symptoms should be given far greater weight than physical signs. The symptoms indicate an active process. Physical signs indicate the location and extent of the disease. Keep in mind also that the signs remain after the disease becomes inactive or arrested, therefore a child showing signs without symptoms does not require treatment other than general hygiene. Cough is not pathognomonic of tuberculosis, as many pharyngeal and bronchial infections as well as enlarged tonsils and adenoids may produce it. Weakness is the most constant of the warning symptoms. Children with a focus of active tuberculous disease require frequent rest periods. Poor appetite is present in about one-half of the cases coming for treatment. With the sanatorium routine of frequent rest periods, restricted exercise and play and sufficient sleep, practically

all those except the advanced cases begin to regain their appetite and gain in weight.

On admission to the sanatorium about two-thirds of our children were under weight and under developed for their age, but fully one-third were normal or above normal in weight on admission. This should be remembered that in a series of two hundred children 33 per cent. were well developed and nourished and normal in appearance. Symptoms of toxemia in any child, however well they may look, should suggest tuberculosis, and the focus will most often be found at the root of the lung.

TREATMENT.

Children having symptoms of active tuberculosis respond to sanatorium treatment if they are gotten hold of before the tubercle has broken down and the lesion becomes an open one. If, however, the case is advanced and the sputum is positive, the prognosis is not as good as in adults at a corresponding stage of the disease, even when given the best conditions for treatment. Out of five hundred seventy-six admissions of children under thirteen years of age thirty have had positive sputum as found in our laboratory. Of these fourteen have died, five were progressive on discharge, two more are now under treatment as progressive cases, two were discharged as improved, and but five as apparently arrested. Including the progressive cases which were hopeless of improvement, with the known deaths, we have a total of twenty-one out of thirty cases or a death rate of seventy per cent. Other cases, even though some have shown a larger area of lung involvement, but without bacilli appearing in the sputum, almost invariably do well and become arrested cases if left in the sanatorium from one to three years. One year's residence is the minimum period necessary in the average case to obtain arrest.

The order of the day in our children's ward is as follows: Breakfast at 7.15; school for those who attend the morning session, 9 to 11.30; then 30 minutes lying flat on their beds without pillows; then dinner; 1 to 2.30 rest on the bed; then school for those who did not attend in the morning. Each child has a glass of milk at 10 A. M. and 3 P. M., rest on the bed from 4.30 to 5; then supper. Bed time comes at 7 o'clock. The children who are not in school in the morning session have those hours for play, and the children who attend the morning school have the afternoon hours for play. The schedule, as you will see, breaks up the daylight hours into short periods so that there is a frequent change of activities and rest. This is important and the short sessions of school are a rest from physical exercise. We feel

convinced that school has a therapeutic value, because during the months of July and August, when our teachers are away, the children do not show as much improvement in their physical condition as in the other months of the year. It is possible that the summer heat may be partially responsible for this, but the enforced rest from active exercise during the school hours is certainly beneficial.

I am not an advocate of open air schools in this New England climate in the winter months, neither do I think it necessary to sleep out of doors in the extreme cold weather. There may not be such a thing as too much fresh air, but there certainly is such a thing as too much cold air, especially for a debilitated patient. Cool air is stimulating, but severe cold takes away too much bodily heat and may serve to further depress and enfeeble resistance. Our school rooms are of an open window type with sufficient radiation under the windows so that the temperature in winter can be modified and kept above 40, except in the most extreme weather. The school children do their best work, however, when the room temperature is between 45 and 58. Children sitting in a school room having a temperature below freezing have to be wrapped up in clumsy blankets or bags, their fingers are numbed and their minds are dulled from cold. They are not as mentally alert and attentive as they would be if they were in a more comfortable temperature. Because the usual public school buildings have closed windows and the rooms are overheated, it is unnecessary to go to the other extreme and eliminate both rooms and heat. A reasonable provision for both fresh air and artificial heat is the rational solution. These conditions are best met by open window rooms.

The problem of tuberculosis in childhood resolves itself into these premises, tubercle bacilli are omnipresent and children are ubiquitous and all of them are susceptible to infection. The result is that nearly all are infected. The infection usually occurs in the bronchial glands about the hilus and peribronchial tuberculosis is the form it takes if disease follows infection. Only a small percentage of the infected develop the symptoms of disease during childhood. The pulmonary disease of the adults is due to the lighting up of the tuberculous focus which has been quiescent since childhood. To prevent pulmonary tuberculosis in an adult we should treat that individual when he or she was an infected child and do everything possible to increase resistance and create a reserve at that age by improving personal hygiene and home conditions. Keep in mind also that all exposed children in the home of a consumptive are infected. If a child exhibits malaise, undue fatigue, unaccountable febrile attacks, and has signs indicating enlarged bronchial glands, it is evident that infection is passing over

the border line and becoming tuberculous disease. Treatment measures such as I have outlined should cause arrest when in this bronchial stage. If not taken in hand at this most favorable time the disease may smolder on until early adult life, when it develops into its usual pulmonary form. It is probable that childhood infection prevents or makes more difficult additional infection from without in later life. A thoroughly healed focus also increases resistance to tuberculosis to some extent. Unfortunately, however, a tuberculous focus rarely becomes so well healed and walled off but what a lowered vitality, from whatever cause, or other inflammatory pulmonary conditions may break down the old tubercle and allow the released bacilli to spread to new areas. It is useless to attempt to learn the source of infection in the case of an adult with tuberculosis by inquiring about the patient's immediate associates. The truth will be more apt to be gained by asking about his environment and health as a child. An adult need not be afraid of new infection, but he should be taught to have a wholesome respect for that which he has carried about in his tissues since early life.

Tuberculosis workers must reluctantly admit that we have thus far accomplished but little in preventing infection. We can, however, do much toward keeping the infected child from becoming diseased by improving the conditions in the homes and schools. We can also restore to a satisfactory degree of health the diseased child by beginning at the right time and instituting right treatment. This I venture to predict will in time be adopted as the most vulnerable point of attack in the fight against adult tuberculosis. Build up the resistance in childhood that the adult may reap the benefit.

DR. SPALDING: In the absence of anybody else to open the discussion on the excellent papers we have just heard, it is the duty of the President to say something about them. I do not wonder that you are sick and tired of hearing about tuberculosis, but you will hear of it as long as you live, for there will always be cases among us. I have practiced medicine a great many years, and I have noticed it especially from the point of view of the diseases of the eye, ear, nose and throat. I will mention that when I was a young fellow we used to treat these cases locally. We had no idea that some of them might be syphilitic, and that a large majority are of a tuberculous nature. I remember distinctly in my time of seeing two patients that developed tubercular choroiditis. As we knew of nothing better to do, we enucleated the eye. The patients are living now with no further symptoms of tuberculosis, but it is true that, by proper treatment with tuberculin and out-door treatment, those eyes might have been saved, and those patients not have been compelled to go through the rest of their lives with only one eye.

I would like to inquire of one of the gentlemen who has already spoken if there is any possible way of using the skin test in schools? Is there any

risk in examining school children for supposed tuberculosis with the skin examination? Is there any risk to it, and could an ordinary school examiner attend to it? I would also ask this: Do the tonsils in tuberculosis show any particular symptoms that would indicate that tuberculosis was the cause of the enlarged tonsils? Are they crepitant? Do they have any different appearance? Is there any more discharge from them than there is from an enlarged tonsil that has no connection with a tuberculous diathesis?

I am very glad to note that they have open air schools for the treatment of the children who are tuberculous, and I would also be very glad to see them used for children who are not tuberculous. I would be glad to know from anybody who is posted whether there is any system of filtration of the air carried out in those schools by screen? Or is there any need of it in the country where the air is so fresh? Would it be desirable if we had a school for the tuberculous, for instance, in the neighborhood of Portland, where there is a large amount of coal-dust from the railroads, the factories and other places, to have the windows screened with cotton screens to sufficiently admit the light? I would inquire if anything has been accomplished in this direction of advantage to the tuberculous?

What strikes me as very curious is that no mention seems to be made of any medical treatment of tuberculosis. Has the medical treatment of tuberculosis entirely disappeared? Do we rely exclusively on milk, air, rest and exercise? I see no mention of any medicine. Is medicine of no value, and will anybody suggest some treatment that might be of use to patients before they go into the sanatorium or after they come out?

What struck me as very interesting is the question of the treatment or examination of tuberculous patients with the X-ray. The wonders accomplished by the X-ray are certainly very remarkable, and I would be glad to know if they give you a pretty good diagnosis of the state of affairs, and if the X-ray pictures change from time to time as the patient progresses, or grows worse, sufficient to prove the value of the use of the X-ray.

Finally, it seems to me that a tuberculosis pavilion, to be attached to some general hospital, is one of the best ideas suggested for a long time. Of course the money question is to be considered. Do we need a strong, permanent building made of brick, iron, stone or cement, or would an ordinary wooden building be sufficient to take care of such patients? Should the building be one that would cost a great deal of money, or could it be made cheaper and just as much good be accomplished?

Now, gentlemen, I am not a practitioner of medicine, but these ideas occur to me as I read the papers. I am speaking now to you with the idea that these ideas may offer suggestions for somebody to say something in the discussion of these two very competent and satisfactory papers that we have heard concerning a disease that will always be with us. Let us not be sick and tired of tuberculosis, but let us study as long as we live, and do the best we can with it. I shall be very glad to hear from some volunteer speaker on these two papers.

DR. SHAW: I have made no notes of what Dr. Spalding has asked for. He has asked about medical treatment for tuberculosis. I do not believe that we have anything to-day that is eminently satisfactory. Various things have been tried, including the tuberculin treatment, which has been of value in some cases, but its use is being discontinued. We have not used it in our institution.

With regard to the X-ray diagnosis, I believe Dr. Hardy can tell you about that. He has a machine and records.

A MEMBER: What about the skin test?

DR. SHAW: I believe Dr. Chadwick can tell you about that better than I can. Dr. Hardy mentioned about the diagnosis and early recognition. This seems to be quite a problem. The question of education seems also to be quite a problem. It would seem wise from an economic standpoint to use the general hospitals for tuberculosis. They have their administration right at hand; the overhead expense would be still the same, and it should not entail any great expense in regard to buildings.

PRESIDENT SPALDING: Dr. Hardy made some remarks about the thoughtlessness of general practitioners in regard to overlooking cases of tuberculosis, and that reminds me of a very curious case. I met a man as I was coming down the street the other day, and I said, "How do you do this morning?" He said, "I am perfectly well." I said, "I am glad to hear that. Do you have any rise in temperature now?" "No," he said, "I followed your advice of several years ago; I went away and took the open air treatment, and I am thoroughly well, I think. I rest a little from my work every day, but I get along perfectly well." The history of the case was this: This man had a bad cough and was examined by two trained specialists, and neither of them thought that there was anything the matter with him. He dropped into my office one day. I felt his pulse and touched his forehead. It was late in the afternoon, and the idea came to me that there was something wrong, that he did not have a throat trouble, but that there was some trouble. I sterilized my thermometer and took his temperature for three minutes, as ordered by nurses at the Maine General Hospital under pain of expulsion, and I found that he had a temperature. I told him to come in the next afternoon at the same hour and I would take his temperature again. He came in the next afternoon and he had the same temperature. I said, "Go and see your doctor." He says, "I employ so and so." I said, "Go and see him and tell him that I think you need physical treatment and examination." I telephoned the doctor and told him what the man probably had and that he needed treatment. It just happened, by my accidentally touching that man's skin and noticing that it was pretty warm, that I became interested. I might have very easily overlooked his symptoms of tuberculosis, as it proved to be, and I should never have found it out. Probably the man would have gone from one throat specialist to another until somebody had found it out. This shows that in doubtful cases you should always keep a watch on the thermometer.

If no one else has anything to remark, it is in order for Dr. Chadwick to make some further remarks, if he has anything to add to his paper. After that we will be very glad to hear from Dr. Hardy to close the debate.

DR. CHADWICK: In answer to the question about the Von Pierquet test, I would say that that is a very simple procedure and is harmless so far as I am aware. I never knew any child to be injured by it. But I should not put too much dependence upon it. It does not show you much more than you knew before; that is, you can take it for granted that 80 or 90 per cent. of all children will be positive to the Von Pierquet test to the time they are sixteen years old. That simply means that the child is infected. It has no bearing whatever on what you want to know, that is, the child's disease. The same might be

said about an X-ray examination. The shadows given by the X-ray show a thickening of the lung tissue or of the bronchial glands. You have got to depend on your symptoms to determine whether or not that disease is active. The X-ray will show you the scar tissue or make the same shadow as an active process, or a very similar shadow. You must rely on symptoms to determine active disease and whether or not the individual requires treatment. In determining as to school children whether or not they need treatment is a matter of symptoms first and physical examination second.

A MEMBER: How often does a child have temperature?

DR. CHADWICK: Nearly always children of active temperament will have periods of temperature. There will be temperature when over-tired, and then it may run normal for some time. It is a remitting sort of temperature, and if they over-exert themselves or stay up late nights, do not get enough sleep, then, if they have any tuberculous disease, they will show temperature. Rest will take it down.

In regard to tonsils, which your President spoke about, I do not think there is anything significant, any characteristic appearance indicating tuberculous condition of the tonsils in most cases. Occasionally there is, but it is a very rare condition. In removing tonsils of tuberculous children you frequently find an abscess in the tonsil something like a cold abscess in the crypts, which are closed over, encysted. I have frequently had children who did not do well under the ordinary treatment, and have kept them for some months without their gaining. Possibly they might have sore throat, or their temperature would stay up to 99 or 99½ much of the time, and still have but very little to show for it in their lungs. If their tonsils were enlarged, I would remove them, and oftentimes find a crypt filled with cheesy material, and after their removal the child's general health would improve very rapidly.

A MEMBER: Do you remove them unless they are very large

DR. CHADWICK: No, I do not remove them unless there is material enlargement. Small tonsils, unless thoroughly inflamed, I would not touch; that is, I only try to take out the diseased tonsils. That is a small percentage of the cases.

A MEMBER: When do you feel safe to say that the disease would be arrested, or apparently arrested?

DR. CHADWICK: We try to keep a child at least three months with a normal temperature, a normal pulse, and no symptoms of active disease in the lungs.

A MEMBER: In adults?

DR. CHADWICK: The same condition. Home treatment is usually not as effective as sanatorium treatment, for the reason that you cannot carry out the rest at home as well as you can at a sanatorium. It is almost impossible to get a patient to do, alone by themselves, what they will do in the community life of the sanatorium, where they have a clock to go by, take their rest at certain times, their exercise at certain times, and get to bed at the right time. If those things could be regulated as well at home as they are in sanatoriums, the patient probably would do as well; but with friends coming in to visit, and various home duties and activities that are brought to their attention, they

cannot carry out that strict routine as well, and, therefore, they do not do as well. It is impossible to get a patient at home to realize the importance of rest. Rest is by far the most important of all the methods of treating tuberculosis. We try to rest the lung as you would try to put a broken leg in a splint and keep it at rest; it is done for the same purpose. We try to limit the motion of the lung by rest. When the patient is in bed he is breathing fewer times per minute, his heart is beating a fewer times per minute, and the lung is at comparative rest; and that is the object of it. Of the three things, rest, air and food, rest is the most important.

A MEMBER: Do you think anything could be accomplished by instructing teachers in schools?

DR. CHADWICK: Yes, I think that would be a great advantage. If the children in school could be watched and their temperature taken, many cases of early tuberculosis would be discovered. Children should have rest hours at home, in bed, if possible. I believe there are many children in the public schools to-day that would be far better if they had only one session of school a day. I think if they were limited to the morning session, and had the afternoon for out-of-door life, that fewer of them would break down. All children should not go through the same routine regardless of their physical condition. It seems to me there are three groups of children. There are those who are physically well who can go to school the full sessions, morning and afternoon; then there is another group who should go one session a day; and then there is a third group who are exhibiting symptoms of the disease, and who should go to a sanatorium school. The difference between the regular school and the sanatorium school is that in the latter they are obliged to rest on the bed several hours a day, which program cannot be so well carried out at home. I think those are the three classes of children, and, by watching the children carefully in the school, and turning out those who begin to show signs of fatigue, and allowing them to go half days, many of them would be saved from breaking down; fewer would need the sanatorium school.

A MEMBER: What type of children do you send in the afternoon, at your place? What age?

DR. CHADWICK: That is just a matter of convenience in the grading of the school.

A MEMBER: Wouldn't they be apt to run more fever in the afternoon?

DR. CHADWICK: We do not send any children to school who run fever; they are kept in bed.

A MEMBER: How long do you feel obliged to keep a patient at rest in bed? That is, what cases do you give some exercise?

DR. CHADWICK: Do you mean a child, adult, or both?

A MEMBER: Both.

DR. CHADWICK: We keep all our patients in bed who have any fever above $99\frac{1}{2}$; and with adults, as a routine, we put them to bed as soon as they come into the sanatorium, and keep them there for from one to three months, as a routine. We find we get much better results if we put them to bed, regardless of their symptoms, for a few weeks, and then we get them up after they

have had a normal temperature and pulse for some time, and they are then allowed to go to the dining room only for a time. Then the next stage is to give them fifteen minutes' exercise in addition to going to the dining room; then increase that to a half hour, and so on. After they can walk about for half an hour a day without any symptoms, then we give them a little work in the wards, sweeping, dusting or something of that sort. Our patients are seen in consultation by the doctor in charge, that is, our ambulatory patients are seen in his private office once a week, and they are given a card on which are the days of the week; and they record each day the amount of walking they have done, or the amount of work that they have done, and the doctor checks that up with their pulse and temperature and their weight, and, if he thinks they have been doing too much, he cuts down their next week's allotment of work or exercise, or puts them to bed, if need be, until the next week; or, if they have been doing well on what they have been given, he adds more exercise or more work. Of course, the bed patients are seen twice a day; but this private consultation gets to the patient much better than seeing those same people in a ward in a group. You find out many things in private that you cannot in public, things that are worrying the patient, and they are not always medical things. They may have something to do with their financial situation or home cares, which sometimes we can straighten out for the benefit of the patient.

A MEMBER: On what principle is a patient kept in bed for from one to three months?

DR. CHADWICK: To rest their lungs, to make them breathe as shallow and as few times a minute as possible.

I heartily approve of Dr. Hardy's suggestion of caring for advanced progressive cases in connection with general hospitals. I think that is a plan that could be followed with economy and to the advantage of the patient. If the progressive cases could be cared for where relatives could visit them, they would be much more happy and contented, and they would stay until they died; and that is what the health officer wants. He wants to keep that advanced case from associating with the children in the home, and that could be accomplished much better if they had a bed in a near-by hospital. Certainly, there is no danger to the other patients in a general hospital, by having tuberculosis patients in a separate pavilion. I would go even further than that and say that there would be no danger in having them in the same ward with the other patients, because I firmly believe that there is very little danger of adult infection, very little danger of one adult patient infecting another adult patient. I believe that the infection, as I said in my paper, is acquired in childhood, and whether or not tuberculosis develops depends on conditions in later life; things go on that cause a breakdown in vitality, and then the infection which is there, and has been there for years, will start in and become active.

Another thing would be the training of nurses to take care of tuberculous patients. A nurse who graduates from a general hospital at the present time is very poorly equipped to take care of tuberculous patients. In the first place they are nearly always afraid of consumption. It seems to be one of the things that the graduate nurse of the present day has impressed on them more than anything else, that consumption is the most dangerous patient to nurse. They would not hesitate to care for a case of scarlet fever or diphtheria or typhoid half as much as they would to go out and take care of an advanced

consumptive. Now that is all wrong. A nurse in good health, who is not overworked, will not contract consumption from a patient.

A MEMBER: Just what stress do you lay upon heredity?

DR. CHADWICK: I do not think heredity enters into it at all. You do not inherit consumption; you acquire it after birth.

A MEMBER: Do you not inherit a pre-disposition?

DR. CHADWICK: Only as you inherit a low vitality. A child of a sick mother is not likely to be as strong a child, or one that will resist disease as well, as the child of a healthy mother. Only so far would I consider that there is any pre-disposition. I do not think there are any more pre-disposed to tuberculosis than there are to other diseases with which they may come in contact. They have got to acquire the germ after birth; they do not get it before.

A MEMBER: How do children acquire it?

DR. CHADWICK: Our figures show that two-thirds of them probably get it from their relatives at home; their fathers and mothers.

A MEMBER: By drinking from the same dishes?

DR. CHADWICK: Yes. There is no question that the consumptive spreads the germs all about him by coughing. Even when they are careful, they sneeze and they cough without protecting their mouths, many times, and those germs are about the house, about the floors, and a child creeping about the floor, or putting various things in its mouth, as children always do—babies—in that way gets the germ.

A MEMBER: Do they get it from drinking tuberculous milk

DR. CHADWICK: Yes, there is no question but what 10 per cent. of the young children that get it, get it from drinking tuberculous milk. I think, as I said in my paper, that the germ is so widespread that we have got to work on a different line trying to prevent infection. At the present time we cannot prevent infection very much. When we find an adult consumptive, we can be sure that all the children who have lived with that adult are already infected. How are we going to prevent infection? It is already there when we discover the consumptive. It does not do very much good to take that consumptive out except to limit the number of germs that those children are going to inhale and ingest. That does some good, but we have got, not only to take the consumptive out and take care of him, wherever possible, but we have got to take care of the children who have been exposed to that consumptive, and prevent their breaking down. They will be more apt to break down than the children in the next house where there is no consumption, but we cannot be sure that the children in the next house will not break down, because statistics show that one-third had no association with consumptives in their own home. Now where do they get it? Some of them probably get it from milk; but there is no reason to think that 33 per cent. of the children get it from milk.

A MEMBER: I would like to ask what percentage, in your opinion, of cases of pulmonary tuberculosis result from infection of the upper mucous membranes, that is, the mucous membranes above the larynx, and what percentage through the digestive organs, that is, through eating and drinking tuberculous food and milk?

DR. CHADWICK: I do not think there is any way of telling in most cases how the infection got in, whether it got in through the mucous membrane of the throat or through the mucous membrane of the intestines. There is no question but what the bacilli lodge, in almost every instance, in the glands, most commonly the glands relating to the lung; occasionally in the cervical glands. Of course, those cervical glands, we have reason to think, are affected by absorption through the mucous membrane of the throat and the tonsils.

The work that has been done in determining the percentage of bovine infection and human infection has shown only one or two proven cases where the bovine type of bacillus has been found in the lungs. The bovine bacillus is found in the glands, but pulmonary tuberculosis itself has been, except in one or two instances, always in the human form of the bacillus. Now it is open to argument by the bacteriologist as to whether or not that human type of bacillus may be a transient form or the bovine type. That is a thing that is disputed. Some think that it may undergo a change, but there is no way yet by which that can be proven; but the facts are that the pulmonary tuberculosis, thus far, is almost always the human type.

PRESIDENT SPALDING: Has Dr. Hardy anything to say in concluding the discussion?

DR. HARDY: Mr. President, in connection with Dr. Chadwick's paper, according to his views, I think it is very generally accepted that the tuberculosis problem is very largely a problem of the child. If we take proper care of the children, the amount of adult tuberculosis will be very much reduced. In connection with that I want to call your attention to the fact that, very shortly, there is to be a sort of survey of the children of Maine—Babies' Week, I believe it is called. I think the State Department of Health and some association here in Maine are going to take a very general survey of all the children in Maine, and the medical work will be done by the doctors throughout the State. This will give us an opportunity of watching for evidences of tuberculosis in children. I think we ought to bear that in mind.

One other thing! The President seemed to intimate that I was handing something to the profession. I did not intend that at all. I think we will all concede that lung examination is extremely difficult, and one should hardly expect to become proficient in chest examination without considerable opportunity of making chest examinations. I believe that if we are lax in that work, it is because that sort of thing has not been taught in our medical schools. Those things are barred from the hospitals, and we have not been properly trained in that way. I did not mean to intimate that the profession was at all negligent; I think the system of handling the disease is the cause. The medical men of Maine are usually "on the job;" I do not think there is any question about that.

PAMPHLET RECEIVED.

Dr. F. H. Jackson, of Houlton, has favored us with a report of a very curious instance of an intraperitoneal abscess containing round-worms. This must be a very rare state of affairs, and the good results of the operation described in the paper will encourage others to try a similar method.

Necrology.

WILLIAM EDWARD EMERY

It is always with deep regret that we are obliged to mention the early death of our promising young physicians from Maine, for their places are hard to fill. It is also with more than ordinary keenness of grief that we name to day another instance in which one of our younger members has left our ranks forever. His death, too, seems so uncalled for at this juncture in the history of our Association, for it was not



from army service nor from an accident that it occurred. It was due, as we have been informed, to meningitis following not long after an apparently simple nasal operation at Camp Oglethorpe, Georgia, to widen the nasal spaces and straighten a deviated septum.

Young Emery, a son of our former member, Dr. William Edward and Lucy Emery of Surry, Me., was born in that town June 30, 1890, educated at Bucksport Academy and obtained his medical degree at the Dartmouth Medical School in 1914.* He served for a while in two hospitals in Boston, in the Lying-In Hospital in New York, and finally at the hospital in Beverly, Mass., during which time he became a member of the Massachusetts Medical Society. He removed to Bangor in October, 1915, where in a quiet, unostentatious way he was gradually working into a good practice as a specialist in dermatology. He looked like a man determined to carry through whatever he began.

Early in May of this present year he made up his mind to go forward in the defense of the nation, and after rapidly arranging his affairs he was ready for his orders. In this he unconsciously set a good example to others of his age or even older, for he could not understand why any physician with a good physique should not drop everything and do his share in the present conflict. It is true that he had no essentials to keep him at home, unless it were his lonely mother. But even that excuse he set aside and went. He saw with clear vision that the occasion facing the nation was unparalleled in history, and he meant to do his duty without excuses. Scarcely had he left Bangor when the news of his sudden death came back as an echo, as it were, of his footsteps heard not long before upon its pavements. On the eleventh of June, 1918, he ceased to be with us. He is dead at the early age of 28, and has thus become essential to the history of medicine in Maine, and of the medical history of the great Hun War, the greatest which has ever devastated the world with terror, destruction and death of all that is dear to so many of us.

JOSEPH WHITE HUMPHREY PORTER

Caribou.

Once more I am regretfully calling attention to the death of one of our members, a modest, unassuming physician of the Aroostook region, who, though not so many years in practice there, had greatly endeared himself to the agricultural community into which he had cast his lot for life.

Dr. Porter was born in Bangor, March 10, 1878, the son of Byron and Mary Humphrey Porter, studied at Stillwater, Me., and at the University of Maine, where he took the degree of B. S. in 1898. He was medically graduated at the University of Pennsylvania in 1901, and for a year and more studied for eye, ear, nose and throat practice at the Philadelphia Polyclinic, and was Assistant Surgeon to the Eye Dispensary in Philadelphia. About this time he married Miss Alice Gabel, of Lehighthorpe, Penn., and in December, 1902, he settled for special practice in Caribou. He soon obtained there an excellent business, and, what is more, he gained the very highest possible position in the community for his good standing as a citizen and as a man. He took intense interest in everything educational in the region round about, and was, as may be truly said, a leading citizen of the town and a shining light in special medicine in the Aroostook region.

With the oncoming of the great war, Dr. Porter took a prominent part in the enrollment and examination of many recruits, and was planning to go forward himself, when on October 12th he exhibited the first symptoms of the prevailing epidemic, took to his house and his bed on the following day, and pneumonia supervening, he died without a chance for recovery on Sunday the 19th, 1918.

He is mourned by a widow and two children. The memory of his good works in Caribou during his fifteen years of practice and dwelling therein will not soon be forgotten.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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*Editorial Comment.***LOCAL ANAESTHESIA IN SURGICAL OPERATIONS.**

It is rather curious that, in spite of the fact that a Portland medical paper, printed at least twenty years ago, went into the fullest possible details of the uses of cocain, morphia, water and other materials for the production of local anæsthesia for the performance of surgical operations of the greatest variety, hardly anything has ever been done in Maine to cultivate this life-saving device. Some of our surgeons do, in truth, utilize local anæsthesia, but not to the extent that it really deserves.

This thought occurs to us after reading a very late paper on this topic in the *New York Medical Record*, January 25, 1919, in which the writer, Wiener, details his results in two hundred and fifty operations during the autumn of 1918, most of them being operations for appendicitis, acute as well as chronic. The writer has abandoned the use of cocain, novocain, and other toxic drugs, and now relies almost exclusively upon apothesine, which he claims from experience, is non-toxic, absolutely safe, surprisingly effective in deadening the pain of the operation, and is, so far as he can judge, the best local anæsthetic so far discovered up to date. To this he adds adrenalin, concerning which he is equally enthusiastic as concerning apothesine. The ad-

vantages of local anæsthesia have been gone over so many times that it is useless to repeat them here and the only real reason why local anæsthesia should not be used for every operation is simply that some people are afraid. This sensation is on a par with the dread of hospitals experienced by many patients.

In two hundred and seven instances of appendectomy of all sorts there were eight deaths.

Local anæsthesia prevents ether pneumonia, which causes the death of many of our patients, it is exceedingly useful in old age, arteriosclerosis, diabetes and asthenia. To the surgeons of Maine we most heartily commend a careful study of the paper here commented upon, and we trust that in the future more use will be made in our hospitals of local anæsthesia than so far appears to have been the case. Given a non-toxic product as above mentioned, it would seem, sooner or later, that general anæsthesia will be doomed to desuetude.

Book Reviews.

Manual of Vital Function-Testing Methods.

By Dr. Wilfred M. Barton, Associate Professor of Medicine, Georgetown University, etc.

R. G. Badger, Publisher, Boston. Price, \$2.00.

It has occurred to the writer of this book to condense into some three hundred pages an account of the most important function-testing methods bearing on the diagnosis of diseases of the vital function organs of the body. Following this scheme we have here called to our attention, first, the tests for the liver function, then to those of the kidney, pancreas, and heart, and finally of the ductless glands. All of these tests previously scattered about in innumerable medical journals are here brought together under one cover. The idea is excellent, and the carrying of it out has been perfectly accomplished so far as the reviewer can see. The book is handy in shape, light in weight, well printed, pocketable, as one might also say, and provided with a very satisfactory index. Altogether, it is to be commended to the student and practitioner of medicine alike, as a desirable addition to a working medical library.

A SUMMARY OF THE RULES AND REGULATIONS OF THE STATE DEPARTMENT OF HEALTH FOR THE CONTROL OF VENEREAL DISEASE.

By H. E. HITCHCOCK, M. D., Augusta, Maine.

A. A. Surg. U. S. P. H. Division Director.

Because of considerable misunderstanding it is deemed wise to offer a simplified statement of what each section of the venereal disease law provides.

The one great purpose of the whole undertaking is to provide reliable treatment within the means of the venereally infected person and to make sure that he or she gets it, meanwhile protecting the public from the irresponsible carrier of disease.

VENEREAL DISEASE CONTROL REGULATIONS OF THE STATE DEPARTMENT OF HEALTH.

RULE 1.

Section 1 provides:

That every known venereal disease case shall be reported, at least by number, to the State Department of Health (and is theoretically quarantinable).

Section 2:

That the full name and residence shall be reported to the local board of health and the State Department of Health of the venereally diseased person, who becomes a quarantinable case in fact by disobeying orders.

Section 3:

That anybody aware that another person is in danger of becoming infected with venereal disease shall warn such person; also that the source of danger shall be reported to the local health board and to the State Department of Health.

Section 4:

That the State Health Department, when informed, will in turn notify the local health board involved, of the danger; who it is and where the person lives; also assures secrecy on the part of the department.

Section 5:

That the local health board is responsible for the enforcement of health laws within its jurisdiction.

Section 6:

That the patient shall be adequately instructed by his physician.

RULE 2.

Section 1 provides:

That no person arrested or held in restraint shall be released until examined for venereal disease.

Section 2:

That all legally committed persons infected with venereal disease and contagious at the expiration of their term of commitment shall at once be quarantined and treated until their disease is not communicable.

Section 3:

That no discrimination shall be made against the reception and treatment of venereal disease cases in any general hospital, supported in part or in whole by municipal, county or state aid.

Section 4:

For punishment of officials who violate regulations.

RULE 3.

Section 1 provides:

For diligent investigation of venereal disease cases and their source, and authority to examine suspects; also includes as suspects certain persons, such as prostitutes.

RULE 4.

Section 1 provides:

That to spread venereal disease is unlawful; and for the suppression of prostitution as a health measure.

Section 2:

For the responsibility of parents.

Section 3:

Against the giving of certificates of freedom from venereal disease.

RULE 5.

Section 1 provides:

For quarantine of the venereally infected under certain conditions specified in the following sections: 3, 4 and 5.

(Sections 3 and 4 of Rule 5 reveal that quarantine may be readily terminated upon signing the prescribed agreement. Note penalty for violating agreement.)

Section 2:

For responsibility for and limits of quarantine.

Section 3:

For release from quarantine by cure or contract.

Section 4:

For form of agreement or contract of person released from quarantine.

Section 5:

For placarding premises in exceptional instances.

RULE 6.

Provides against incompetent treatment of the venereally diseased.

In order to successfully administer these regulations it is necessary to know where venereal disease exists and what measures are being taken to control it. Therefore certain printed forms are provided for convenience in reporting.

Form V-5 conveys to the State Department of Health certain data in regard to a case of venereal disease, designated by a number printed in red upon the card (for convenience in filing) and mailed by the physician to the State Department of Health.

Form V-4 informs the physician who receives it that his patient is under the care of another physician, thus assuring treatment and supervision of the venereal disease case.

Form V-2 is to warn the local health officer or secretary of the health board, and the State Department of Health, that a vicious or an irresponsible person, infected with venereal disease, is at large and not under proper treatment or control, and is therefore a public menace.

Form V-1 is mailed to the local health official from the State Department of Health with the names of certain persons known to be infected with venereal disease and not under competent control. His first duty is to place these persons under quarantine until they sign the form of agreement, which releases them at once. In case of a refusal to sign, such person shall be kept in quarantine until not infectious.

Form V-6, when signed by the patient, binds him or her to take proper treatment and to report to the health official as he may direct.

Form V-7 affords evidence that the patient is aware of his or her condition and that he or she has agreed to obey the physician and is

informed of the requirements of the law in the case. This the physician files for his own convenience and information.

It would complete the chain of control measures if a form were provided upon which the physician would notify the health department what disposal had been made of a case discharged or referred, as there is now no assurance, other than the patient's word, that orders will be obeyed.

The physician bears the same relation to any problem of this sort that any citizen does to matters of conduct in his relation to the law, and uses his best judgment, not in evading the law but in furthering its beneficent purposes.

Personal advice and blank forms will be supplied at any time by the State Department of Health, which in turn requests the co-operation of physicians, local boards of health and laymen, in this important work.

PAMPHLET RECEIVED.

"Anthrax at Camp Dodge, Iowa," by Lieut. Carl G. Dennett, U. S. A. M. C. (Saco and China, Maine), has been received by us and read, and it proves to be a pamphlet of value to the profession. We are very glad indeed to see our younger members engaged in careful studies in medicine and surgery, and additionally in spreading their results abroad, for the benefit of the profession, by publishing them in the medical magazines.

FOR SALE

As the owner has installed a Snooks X-ray machine he desires to sell the Static machine which he now uses. It is in very good repair and can be run by either water motor or by hand. Will sell very cheap. Address this Journal.

THE STUDENTS' LIBRARY ASSOCIATION of the Middlesex College of Medicine and Surgery solicits donations of Medical and Scientific Libraries, Medical Books, bound and unbound volumes of back numbers of Medical and Scientific Magazines, and funds for current American and Foreign Medical Journals.

JENNIE HRABA, Class '21

Association Secretary

UNIVERSITY OF MASSACHUSETTS SCHOOL OF MEDICINE
EAST CAMBRIDGE, MASS.

PERSONAL NEWS AND NOTES.

Among the men recently returned home from U. S. service are: Major W. L. Haskell, Lewiston; Captain S. E. Fisher, O. E. Haney, Alfred Mitchell, M. C. Webber, F. Y. Gilbert, Portland; L. M. Howes, Allan Woodcock, Bangor; H. L. Kilgore, Belfast; S. S. Mullin, Bath; C. S. Scamman, Millinocket; F. E. Wheeler, West Paris; F. N. Whittier, Brunswick; Lieutenants N. Bisson, Waterville; I. B. Gage, Atlantic; Paul S. Hill, Biddeford; P. O. Hopkins, Bingham; J. G. Hutchins, Camden; T. E. Makepeace, Lewiston; J. L. Pepper, Madison; J. O. Piper, Solon; A. L. Stanwood, Rumford; F. E. Rowe, Augusta; R. R. Tibbets, Bethel; R. D. Walton, Frankfort.

Dr. Ansel S. Davis, of Springvale, has been elected President of the York County Medical Society for the current year, instead of Dr. Kendall, as previously and erroneously mentioned in the JOURNAL.

Dr. Charles E. Cook, of South Berwick, M. C. U. S. A. has been promoted to Major, and is now in a base hospital overseas, attending to the sick and wounded, and making the most of his abundant opportunities to learn the latest novelties in war medicine and surgery. Major Cook was one of the first of our members to volunteer, and we congratulate him on his well deserved and rapid promotions.

The congratulations of the profession go forward with pleasure to our comrade in medicine, Dr. Alexander C. Hagerthy, on the occasion lately of his election for the eleventh time to the Mayoralty of the City of Ellsworth. Very few men have a record, anywhere, equal to this.

We note that Dr. C. A. Wadham, of Fort Fairfield, U. S. N. M. R. C., and Dr. O. F. Larson, of Machias, also of the U. S. N. R. C., have received an honorable discharge from the U. S. Navy and resumed practice in their original fields of business.

CUMBERLAND COUNTY MEDICAL SOCIETY.

At a meeting held on the 25th of March, the following officers were elected for the year:

President, Dr. Lucinda B. Hatch.

Vice President, Dr. Harry E. Emery.

Secretary and Treasurer, Dr. E. E. Holt, Jr.

Censor, Dr. Stanley P. Warren.

COUNCIL OF NATIONAL DEFENSE.

The Council of National Defense authorizes the following:

Characterizing the work of the volunteer Medical Service Corps and the Medical Section of the Council of National Defense as "a very striking demonstration of the American spirit," Dr. Edward P. Davis, president of the Corps, paid tribute to the patriotism of American civilian doctors at the final meeting of the Central Governing Board of the Corps, held in Washington March fourteenth, prior to the termination of its war-time activities April 1.

A report submitted at the meeting showed that nearly 70,000 applications have been received from physicians for membership in the Corps, of which 56,540 had been received and coded prior to the signing of the armistice, November 11, 1918. Qualifications of these civilian doctors, classified and coded on cards, will be placed in the Library of the Surgeon General of the Army, where they will be accessible to all governmental departments for all time to come. With the approximately 40,000 medical officers additional, who are in the Army, Navy and Public Health Service, practically all the able-bodied, eligible doctors of the country will be listed, available for the nation's needs. Usually there are said to be about 150,000 physicians in the United States, but this total includes a large proportion of superannuated, disabled or ineligible.

Dr. Franklin Martin, Chairman of the General Medical Board of the Council of National Defense, expressed his warm appreciation of the co-operation he has received from the



Prof. Anderson *Blasts Every Food Cell in Whole Wheat and Rice*

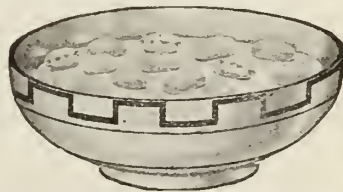
Prof. A. P. Anderson, formerly of Columbia University, solved the problem of steam exploding ALL the food cells in whole grain. The best other forms of cooking, baking or toasting fail to do that.

He seals the grains in guns, and resolves the guns for sixty minutes in 550 degrees of heat. Thus the moisture in each food cell is changed to steam.

When the guns are shot the steam explodes. In every kernel occur over 100 million explosions—one for every food cell.

The grains come out in bubble form, eight times normal size. They are thin, flaky, toasted tidbits with a nut-like taste. With cream and sugar or in bowls of milk they are veritable food confections.

The result of this process is easy, complete digestion. Whole grains are made inviting. Thousands of physicians, in many conditions, now advise this form of grain food.



The Quaker Oats Company

Sole Makers

**Puffed Wheat
Puffed Rice
Corn Puffs**

All Steam-Exploded Grains (3070)

medical profession of the country and his firm belief in the value of the records of the Volunteer Medical Service Corps.

Dr. Davis said, in part: 'This Volunteer Medical Service Corps and the work of the Medical Section of the Council of National Defense has been a very striking demonstration of the American spirit in more ways than we have imagined. I have always thought of a remark made by the President when the whole thing was in full swing, just about the time the nation had gotten its stride. He said that the men who were staying in this country were having the hardest time. That was true. You take the medical men who actually went into service. Of course some of them did office work in Washington, but the men whom I know who have been in the camps here—whether they got to Europe or not—say they have had the time of their lives.

"One man, my assistant, said: 'I am just coming back from a year's freedom from responsibility, except for the immediate performance of my duties.' Another man, who is probably the best X-ray man in the Army, said his career in the Army has been the happiest time he has ever known, because he has worked scientifically without interruption. They had the privilege of being free to concentrate their minds on duty, and I think the remark made by Dr. Studdiford in New York the other night is to the point—that there has not been in the past year in the practice of medicine in the United States one single easy, pleasant, satisfactory thing. He said he hoped he would never have to live to go through another such year.

"When you consider the burden thrown upon the profession of this country by the shortage of resident membership, taking away assistants, nurses, laboratory men; the influenza epidemic, with the consequent increase in morbidity and mortality, and the strain upon the population which is now showing itself, it has been a most hectic war season. I don't think any profession has met a similar crisis in civilization as nobly as did the American profession, and no small part of the moral value and success of the profession was due to this Corps. The fact that we had a Corps where the men could record themselves who did not go to the front had an enormous moral value.

"I personally desire to testify to the pleasure it has been for me to do what I have done. And I have sincerely appreciated the honor which has been given to me.

To about 13,000 doctors whose applications for membership in the Volunteer Medical Service Corps had been received before the armistice was signed, but which had not been acted upon by their state committees, now dissolved, Dr. Davis is sending the following letter:

From: Volunteer Medical Service Corps, Council of National Defense.
To: Applicants for membership.

1. With the cessation of hostilities subsequent to the signing of the armistice, the Council of National Defense, under which the Volunteer Medical Service Corps was organized, asked that the activities of that Corps be terminated, and Surgeon General Ireland of the Army requested that the valuable records of the Corps be given place in the Library of the Surgeon General, where they will be maintained permanently for reference by the various government bureaus.

2. Your application for membership in this Corps, we regret to say, was not acted upon by your State and County Committees before those committees were automatically released, and, therefore, we are unable to complete your membership by furnishing you with the visible evidences of your tender of service, viz., the insignia and certificate of the Corps. We wish you to know, however, that your patriotic offer of service to your government has been received and your qualifications as outlined on the Volunteer Medical Service Corps application blank have been transferred to permanent code cards, which are to be preserved as an important record of the war.

3. We also wish you to know that those of us who have had the responsibility of organizing and enrolling the medical profession of the country appreciate the value of your offer of service and thank you for it from the bottom of our hearts. This includes the Secretary of War, who presides over the Council of National Defense which authorized the Volunteer Medical Service Corps, the Secretaries of the Navy, the Interior, Agriculture, Commerce and Labor, the members of the Council, and the President of the United States who appointed the Council of National Defense and who



For Those Who Reject Clear Bran

There are many, as you know.

Bran to them is a forced diet, and they don't continue long.

We make the bran dish a luxury. We hide the bran in flavory flakes of wheat.

It is flake bran — not ground bran. It is concealed in a food of which nobody tires. And the food is now sold everywhere.

You will be surprised at how much bran people eat in this way.

Pettijohn's

Rolled Wheat — 25% Bran

A breakfast dainty whose flavory flakes hide 25 per cent of bran.

Also Pettijohn's Flour — 75 per cent fine patent flour, 25 per cent bran. Use like Graham flour in any recipe.

(3072)

definitely approved the Volunteer Medical Service Corps in the following words: "I am very happy to give my approval to the plans which you have submitted, both because of the usefulness of the Volunteer Medical Service Corps and also because it gives me an opportunity to express to you, and through you to the medical profession, my deep appreciation of the splendid service which the whole profession has rendered to the nation with great enthusiasm from the beginning of the present emergency."

4. Finally, may I express to you on behalf of the Central Governing Board of the Volunteer Medical Service Corps its personal thanks for your generous response to its request for an offer of your services at a time when it appeared they would be so urgently needed by the nation.

EDWARD P. DAVIS, M. D.,
President, Volunteer Medical Service Corps.

THE NEW VENEREAL MARRIAGE LAW FOR MAINE.

In order that every member of the Association may see the points at which our fellow member, Dr. G. A. Phillips, of Bar Harbor, was aiming in his proposed law under the above title, we are printing in full in the JOURNAL, as a matter of perpetual medical record, his speech on the occasion of introducing the bill. To this we add a reprint of the law as actually passed by the Legislature and signed by the Governor. Let all physicians bear this new law in mind.

Dr. Phillips has, in our opinion, accomplished a wonderful advance in preventing the extension of the venereal peril so deadly to our people. Few men have the courage to speak concerning its danger to all of us in one way and another, and fewer still could have gracefully embodied in words the true opinion of all of our members. To Dr. Phillips the State owes a gratitude that cannot too plainly and openly be expressed, and the editors of the JOURNAL beg leave to offer him the encouragement of their abundant and sincere thanks for work so well done in improving the marriage laws of the State and the safer and saner prevention of inherited disease.

Without further preliminary, we call attention to the remarks and the law as passed.

Remarks of Dr. Phillips, of Bar Harbor, on an Act relative to the marriage of persons having Syphilis.

MR. PHILLIPS, of Bar Harbor: Mr. Speaker and Gentlemen of the House: It is with something of trepidation that I encroach upon the few moments of time your courtesy has loaned me.

I must ask you, in speaking of this subject, to grant me full consideration for my lack of experience in public speaking and supply in the larger wisdom belonging to many of you in public affairs the lack belonging to me. But assuredly you may believe me, however my words may stumble in saying it, that with all the intensity of my being I believe that awful wrong to which I refer, and protection from which for future generations I implore at your hands, needs the weapons of defense that this Legislature can give and should receive the remedy within our power to bestow.

I wish to say here that the amendments which keep from these patients the publicity of exposure by public record such as is given to other contagious diseases, as smallpox, etc., has been done at the suggestion of the highest official medical authority in the United States, as is also the change that causes the State Department of Health to prescribe the methods of diagnosis and places the reporting of patients (so craven as to ignore the suggestion of the physician) to the health officers in the town or district in which the patient resides. Consequently no man except those so vile as to ignore everything decent and right need fear any exposure whatever and these need all they can get.

Among the awful diseases of ancient and modern civilization whose strangling power has wrecked thrones are cancer, tuberculosis and syphilis. It is the latter, nurtured by false concern over publicity, that has swept thousands into disaster, that I have begged a few moments of your hurried time to discuss. In this presence among men of affairs not ignorant of the methods by which this reeking and filthy virus enters into the destruction of the race it is not needed that I rehearse them in detail. It may not be amiss, however, if I state a few facts proven by scientific research.

Syphilis in the one who primarily contracts it is, under proper conditions, practically curable. So far as the purpose of this bill is concerned, in most of its inherited forms it is absolutely incurable. Further, as is now well authenticated, the symptoms of inherited syphilis are so different, so manifold, that it is frequently unobserved. The blindness, the hardened brain cells, the locomotor ataxias, the imbeciles, the hundreds of symptoms meaning disease and death to offspring often are unchallenged and unseen in its inherited form. There is but one blessing among them all, the abortions it produces. For the purpose of which I advise it is sufficient to know that the sins of the father are visited unto the children of the third and fourth generation.

It is awful, horrible beyond measure—the healthy, ambitious, courageous youth, reaching forth into the glory of fighting manhood, smashing against this bulkhead of ruin and shame. This is not fancy; it is as true as the living God. It should be said, it is right that it should be said, that other ways than the common one may convey syphilis and often does. When I call to your attention the fact that every country burying place, every hamlet which has its sacred and hallowed spot, has among its graves always its share that never should have been, had a law like this which I advise been in power. I am not talking sentiment but facts that nothing can blot out. It stands, this accursed disease, as in past ages, reaping with its sickle from the wisest and best. It knows no rank or title. It hangs its sign of death at the door of the highest in power and wisdom as often as the ignorant and poor.

Believe me, I am not blaming the man who contracts this disease more than his neighbor whose good fortune alone enables him to escape, but no man knowingly and no man ignorantly need under this law make this wicked mistake. If it were my purpose to stir your emotions by recital of cases, if I chose to make this argument one of sentiment rather than of cold logic, I surely might stir some of you to action. May I mention one case.

In the neighboring county where I live is a young man, comparatively, 45 or 50 years old, to whom I have been asked by many of you to carry messages of good will when I see him—which is a splendid habit, by the way, of this House. I met him on the train only a week ago and I carried the messages that many members of this House sent. I hope I will never see him again. He stood there with a hand on the shoulder of his son, being led wherever he would go, stone blind forever, through no fault of his own.

This great war, that is destined to lift the world over many centuries of progress, has not failed us here. The under world, the diseased world, with its appalling dangers, the war has opened to our view, has also revealed the need of the surgeon's knife here, and we must cut and cut deeply if the rotting ulcer is to be removed.

I have no faith in that medical ethics that covers crime, or worse than crime, that will not betray a victim of sin but will betray the babe at its mother's breast, that will not betray the man with his drawn dagger who folds his robe of self righteousness about him as the victims fill their untimely graves, that would not betray Judas but would betray his Lord and Master.

I judge no man's conscience save my own. I am not here to question your right of judgment. Far be it from me to pose as



Weak Arch and Flat-foot—

that need mechanical correction are very prevalent and frequently are associated with painful heel, callouses on sole, fatigue, nervousness, neurasthenia, physical exhaustion and rheumatic tendencies. Heavy people and those who are constantly on their feet, and whose occupation requires them to assume a posture conducive to the weakening of the leg and foot muscles, are usually victims of these complaints. The corrective treatment is simple. Remove predisposing causes such as short hosiery, improperly fitted or constructed shoes, and have patient fitted to

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which are scientifically constructed to relieve muscular and ligamentous strain, remove abnormal pressure and restore feet to usefulness. There are distinct types of appliances for each condition. All quickly and easily adjusted to any degree of elevation or curvature, assuring the physician dependable results.

Leading shoe dealers and surgical supply houses in every locality carry Dr. Scholl's Appliances and have also been instructed in Anatomy of the Foot and the proper method of adjusting the appliances to fit both foot and shoe.

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Write for important pamphlet just published, "Foot Weakness and Correction for the Physician," and a chart of Foot exercises as endorsed by the United States Army Medical Dept.

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keeper of your duties to God or man, but for me, knowing the awful history of these things—the deaths and living deaths along this trail, where men and women perish, or worse than perish, in generation after generation, through no fault of their own, the pallor of disease with its entailing unhappiness where their natural right is health and happiness, where one in ten of men and women go to untimely graves by some man or woman's sin—if I, knowing this and more, should fail in voice and vote to protect these unborn generations, then God in Heaven have mercy on my cowardly soul.

The argument often used to put this grave and great issue aside has been to wait until the larger centers and States passed upon it. Mr. Speaker and Gentlemen of the House: Nearly a century ago some genius with prophetic vision wove into the warp and woof, into the texture of our State, a motto not yet, thank God, betrayed—"I direct." From the conduct and voice of every son and daughter in this State whose names are to stand immortal in its annals cowardice has had no part. From King to Milliken, our present Governor, whose name is courage, cowardice has had no part. In every field in which men have stood apart from their fellows cowardice has had no part. In literature and science, in every branch that helped to make our State great, cowardice has had no part. May we hope our motto will not fail us to-day, in the hearts of our people may it still stand secure, never successfully assailed.

I hesitate, Mr. Speaker and Gentlemen, to take your hurried time for further discussion, but this pitiless enemy of mankind must be slain, its accursed power must be wiped from the kingdom of man. Let us marshal every force in our State that shall help to make clean and pure every life and every home within the boundary of its splendid domain. (Applause.)

Be it enacted by the People of the State of Maine, as follows:

Section 1. No person having syphilis shall marry until he has a certificate from the attending physician or physicians that he is cured of syphilis. The State Board of Health is hereby empowered to make regulations prescribing the methods to be employed in diagnosing said disease.

Sec. 2. Every physician shall keep a record of all cases of syphilis that come under his observation and care, and shall use reasonable means to ascertain the intentions of syphilitic patients as to marriage. The physician shall warn said patients of the legal, moral and physical evils of marriage contracted by them. If the physician learns that a patient as aforesaid has filed intentions of marriage as required by law, or if the physician believes that the patient as aforesaid intends to marry, the physician shall notify the Local Board of Health or the health officer in the town or city in which the patient resides, who are hereby empowered to notify the other party to the intended marriage.

Sec. 3. Any person failing to comply with the provisions of sections 1 and 2 and any physician making a certificate as aforesaid

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A new dressing for burns, granulations and similar lesions.

Manufactured by the Standard Oil Company of Indiana, and guaranteed by them to be free from deleterious matters, and so packed as to insure it against all contamination.

Stanolind Surgical Wax has a sufficiently low melting point so that when fluid the possibility of burning healthy tissue is precluded.

Its correct ductile and plastic features make it adaptable to surface irregularities without breaking.

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Each color, however, has a definite and fixed place in the requirements

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The Standard Oil Company, because of its comprehensive facilities, is enabled to sell Stanolind Petrolatum at unusually low prices.

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Manufacturers of Medicinal Products from Petroleum

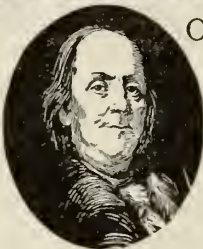
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falsely shall be punished by imprisonment for not less than three months nor more than one year or by fine of not more than five hundred dollars or less than two hundred dollars or both. Municipal and police courts and trial justices shall have jurisdiction of the above concurrently with Superior and Supreme Judicial Courts.

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*Keep on
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IF BABIES WERE STANDARDIZED

A Standard Mixture of Food Materials would suffice for their artificial Feeding
BUT THE BABY HAS AN INDIVIDUAL DIGESTION

Requiring individual consideration from the infant feeder. The arrangement of the diet for the individual baby marks the difference between success and failure in infant feeding

Different Babies

of the same age require different quantities of the diet constituents. Sometimes sugar is temporarily withdrawn entirely from the diet. Sometimes one salt and sometimes another is added to the diet.



Different Salts in the Diet yield different Results

Sodium Chloride has a value where an infant suffers from diarrhoea. Potassium Carbonate acts generally as a corrective in the constipation of infants.

These salts are classed as constructive food material.

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No. 1. With Sodium Chloride, 2% — No. 2 Unsalted — No. 3 With Potassium Carbonate, 2%

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A trial will convince you of our accuracy and promptness.

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A Comprehensive Physicians' and Surgeons' Liability Policy with Indemnity Limitations of \$5,000 and \$15,000. The premium is \$12.50 regardless of the number insuring, and the company is one of the strongest in the world—The Hartford.

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THROUGH INTESTINAL ABSORPTION

Upon the theory that the presence of *Bacilli Bulgarici* in the intestines inhibits the growth or multiplication of toxine producing bacteria.

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Containing large numbers of active and viable benign organisms

ARE INDICATED

CONSERVATIVE CLINICIANS

have continuously used them as an intestinal anti-fermentative and antiputrefactive agent during the last seven or eight years.

In tubes of 50 tablets

Each dose: 2 to 4 tablets with meals

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The general weakness consequent on poor assimilation soon affects the working ability of the digestive apparatus itself.

Conversely, when proper assimilation once begins, the organs of assimilation themselves quickly share the tonic effects. An acceptable food therefore is the important factor in breaking the vicious circle. Time and again

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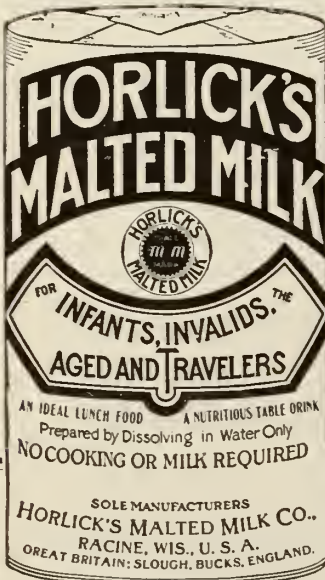
has acted as the starter for infants and invalids with disturbed digestive functions. Denno's produces a modification of milk that is exceedingly bland. The fine, flocculent curd formed in the stomach is non-irritating and in best possible form to be readily assimilated.

Samples of Denno's together with analysis, feeding formulas, etc., sent on request.

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which even require the addition of milk
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Simply use a spoon

Dissolves

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The simplest way at hand may be used to prepare "Horlick's" the Original Malted Milk. It dissolves readily in either hot or cold water—no caking or other undesirable characteristics of imitations—no marketing of a product in an experimental condition.

"Horlick's" is finished. The process is complete—having been perfected by the experience of over ½ century and by the use of ingredients of highest quality and uniformity.

The medical profession, as a result, have

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Mixed Vaccines

The Vital Statistics of the Army, as well as agglutinin and Bactericidal experiments, have established:

First—That vaccination against Typhoid only does not protect against Paratyphoid “A” or “B,” but that it does protect against Typhoid.

Second—That vaccination against Paratyphoid “A” protects against that infection but does not protect against Typhoid or Paratyphoid “B.”

Third—That vaccinations against Paratyphoid “B” likewise protects against that infection only.

Fourth—That vaccination against all three infections does definitely protect against all three.

Fifth—That the protection conferred and the results of agglutination tests, are identically the same whether the individual is immunized against each organism separately or whether the vaccines are given in combination.

Sixth—That the “Non-Specific-Reaction” of Typhoid vaccination is of no avail as a protection against the closely allied Paratyphoid infections.

Of course it is not always safe to reason from analogy. On the other hand is it not well to preserve the open mind and consider if there may not be merit in combinations of vaccines other than Typhoid-Paratyphoid, even though the immunizing response is less distinct and of shorter duration?

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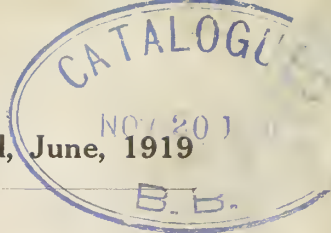
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Maine Medical Association meets at Portland, June, 1919



THE JOURNAL

OF



THE

Maine Medical Association.

The Official Organ of the State and County Medical Societies.

VOL. IX, No. 10

MAY, 1919.

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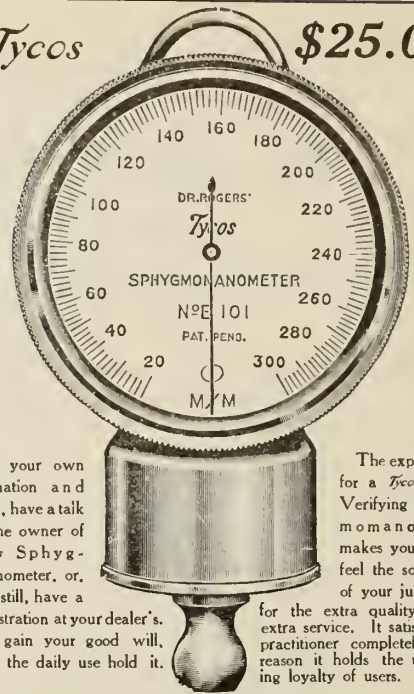
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"SOME POINTS IN THE PHYSIOLOGY OF DIGESTION."

By J. S. JAMIESON, M. D., Portland, Me.

The first point to be referred to in this discussion is the *Movements of the Stomach*.

During life, the shape of the stomach is not at all like the form it assumes after death, the form we are accustomed to see in the dissecting and autopsy rooms. It is not pear-shaped, but, in the upright position of the body, has been compared to the capital letter "J", and may therefore be divided into two parts, corresponding to the down-stroke and short up-stroke of that letter. The upper part lies vertically, is long, oval in shape, and consists of the cardiac end and greater part of the body; and it acts as a reservoir. The lower or pyloric portion lies in a horizontal or slightly ascending position, is narrow and tubular in shape, and acts as a disintegrating and mixing machine. These two portions, then, behave in digestion quite differently from each other.

The stomach, when empty, is in a state of slight tonic contraction. When food is introduced the walls relax and the first food spreads over the stomach, forming a lining layer to the mucous membrane. The next food that enters, mixed with saliva and mucin, lies more or less encapsuled inside this layer and is thus protected for a time from the acid gastric juice. Thus salivary digestion, which requires an alkaline medium, is permitted to go on for varying periods up to an hour.

Soon after food enters, movements begin, and it is to be at once noted that stomach movements are confined entirely to the pyloric portion. Peristaltic waves begin at a band of circular muscle fibres that divides the reservoir from the pyloric portion and proceed at regular intervals up to the pylorus. These waves continue, at a frequency of three to the minute, as long as food is in the stomach and result in disintegration of the food and its thorough admixture with the gastric juice. When the contents of the pyloric portion become sufficiently acid, the pyloric sphincter relaxes, peristalsis forces the food into the duodenum and the sphincter contracts again, and—this point is of importance—it remains contracted until the alkaline juice of the duodenum has neutralized the acidity of the food it has just received. Thus sufficient acidity in the stomach opens the pylorus; or, to state the situation more correctly, in the course of ordinary digestion two chemical conditions must be present before the pylorus opens, sufficient acidity on the stomach side, and alkalinity on the duodenal side. On the other hand, acidity on the duodenal side closes the pylorus. This opening and closing of the pylorus goes on until the stomach is empty. After that, Hertz states, the pylorus remains open, and bile and duodenal contents pass in and out of the stomach without causing any discomfort.

Not only the chemical but also the physical condition of the food is important. Before food is permitted to pass the pylorus it must be in a condition of thorough physical disintegration. If, for example, a large portion of solid food comes against the relaxed pylorus, the sphincter contracts spasmodically and the result is stomach-ache. In such cases, the relief obtained by hot drinks and hot external applications is explained by the fact that the warmth relaxes the spasmodic contraction of the pylorus.

The stomach has a sorting out power over the different food constituents. Water is expelled almost as soon as it enters, hence the advantage of prescribing water to be drunk on an empty stomach. Carbohydrates are permitted to leave much more quickly than proteins and proteins more quickly than fats. Milk, like water, would probably leave the stomach early, but is prevented from doing so by being coagulated by the rennin.

Various conditions hinder peristalsis and delay the opening of the pylorus, *e. g.*, emotion (especially fear), fever, abdominal operations, indigestible food. One piece of indigestible food may cause the retention of a whole meal for hours. It used to be a common saying that "Cheese digests everything but itself." This arose from the fact that a patient, having eaten a meal containing a large piece of un-

chewed, hard cheese, frequently becomes ill some hours later and vomits the entire meal, all of it properly disintegrated excepting the offending piece of cheese.

Hyperchlorhydria is another cause of delay in pyloric opening. Hyperchlorhydria causes prolonged and often painful spasm of the pylorus and so leads to increased retention of stomach contents, because what passes out of the stomach has such a high grade of acidity that it takes the duodenum a long time to neutralize it, and until it is neutralized, as we have seen, the pylorus refuses to reopen.

All this refers to the pyloric portion. What of the reservoir above? It feeds the mixing machine: but not by active peristalsis. While the pyloric portion is hard at work the reservoir remains in a condition of firm tonic contraction and this condition plus the force of gravity is sufficient to pass the food, portion by portion, into the mixer.

To discuss next the *Movements of the Small Intestine*. They are chiefly two: peristalsis and rhythmic segmentation. When a portion of food is descending the small intestine the muscle wall immediately below it relaxes and the muscle wall immediately above it contracts: the food descends a little, and the same process is repeated again and again. This is peristalsis and may be defined as a series of waves of relaxation pursued by a series of waves of constriction. Rhythmic segmentation movements consist of rhythmical contraction of the circular fibres of the intestine whereby the intestine is, as it were, pinched into segments again and again like the segments in a chain of sausages. As the object of peristalsis is the onward propulsion of the food, so the object of rhythmic segmentation is the thorough admixture of the food with the digestive juices. Incoördination of the peristaltic movements, in which the relaxation in front of the food does not coincide with the constriction behind, results in intestinal colic. On the other hand, an exaggeration of the rhythmic segmentation movements, especially in hunger and in nervous subjects, is the cause of borborygmi.

The rate of peristalsis is about one inch per minute, so that food leaving the stomach takes about four hours to travel through the twenty feet of small intestine. Contrast this with the rate of progress in the large intestine, where the figures are almost exactly reversed, the food, or food debris taking about twenty hours to travel through the four feet from cæcum to pelvic colon.

These movements of the small intestine have another function: they favor absorption by compressing the small venous radicles and the lacteals of the bowel wall and so starting off the absorbed food on its way to the liver and thoracic duct respectively.

At the ileocaecal valve there is a sphincter which remains closed, and prevents food from reaching the cæcum until time has been allowed for proper absorption. Whenever food is introduced into the stomach, this sphincter is reflexly inhibited and the remaining contents of the ileum are allowed to enter the cæcum. Under certain abnormal circumstances, *e. g.*, chronic appendicitis and adhesions in the regions of the cæcum, this valve has been shown to remain closed in contraction for as long a period as twenty-four hours, constituting one of the few causes for delay in the small bowel—an interesting point to remember.

The Movements of the Large Intestine are entirely different. There is no regular, continuous peristalsis as there is in the small intestine. Instead of that, large waves of peristalsis occur three or four times a day in response to a gastro colic reflex which comes into play when food enters the stomach. Thus we see that the introduction of food into the stomach causes the ileocæcal valve to open, the last contents of the ileum are shot into the cæcum, and a large peristaltic wave passes over the several feet of large intestine, carrying its load forward. But the rate of progress of the intestinal contents is slow, especially at the dependent portions of the bowel, namely, the cæcum and ascending colon, the middle of the transverse colon, and the pelvic colon and rectum, the passage occupying more than twenty hours. The contents of the small intestine as they enter the cæcum are fluid: one of the functions of the large intestine is to absorb water, and the purpose of this slowness of progress is to give the large intestine time to dry its contents finally to the consistence of normal fæces.

These large waves of peristalsis occurring in the large intestine in response to the ingestion of food may be the physiological explanation of "lienteric diarrhœa," and of the pain after food, which is met with in some cases of chronic constipation.

A few words about *Anti-peristalsis* are necessary. Anti-peristalsis in the small intestine is pathological if we make an exception of Boldireff's evidence that regurgitation from the duodenum back into the stomach is a normal process—a point that is still unsettled.

In the large intestine, however, there is evidence that anti-peristalsis occurs. Cannon, experimenting with cats, finds that, between the cæcum and the splenic flexure, the movements are not only peristaltic but also retro-peristaltic, the final onward movement of the intestinal contents being due to the constant pressure exerted from above by the small intestine.

It is stated also that if the call to defecation is denied, anti-

peristalsis occurs in the rectum and pelvic colon, and this can readily be believed.

Surgically, the possibility of anti-peristalsis is important. After the operation of ileo-sigmoidostomy the contents of the ileum enter the sigmoid and are sometimes drawn up by anti-peristalsis into the descending colon and even as far back as the cæcum. In operations involving anastomoses or excisions of the large intestine, this physiological factor must be kept in mind.

Hyperchlorhydria, or excess of hydrochloric acid in the stomach, is an important subject for the medical practitioner, because of its frequency and its association with grave diseases of the abdomen. The normal amount of hydrochloric acid in the stomach is 0.1 to 0.2 per cent.; if more than 0.2 per cent. is present, the condition is known as hyperchlorhydria.

The outstanding characteristic of this condition is "hunger-pain"—a feeling of gnawing in the stomach, ranging in severity from a mere discomfort to a severe pain, occurring two to three hours after meals, and relieved by the administration of food or alkalis. The pain is probably due to spasmodic contraction of the pylorus owing to the prolonged persistence of acidity on the duodenal side. The tongue, in each case, is unusually clean, pink and wet; the cleanest tongues to be found in medical practice are those of patients with hyperchlorhydria. Another interesting phenomenon sometimes found is a periodical copious secretion of saliva—nature's attempt to neutralize the hyperacidity of the stomach.

Along with the increase of hydrochloric acid, there is an increase of pepsin. This rapid over-production of acid and pepsin results in quick digestion of proteins, but it upsets the balance of gastric digestion; in this way:—owing to the excessive and rapid production of hydrochloric acid, the salivary alkaline digestion of starch in the stomach is prematurely stopped, leaving much of the starch to be dealt with, later on, by the pancreatic juice, and so adding to the burden of intestinal digestion.

While hyperchlorhydria must be regarded as a distinct clinical entity, it is not a true disease. Like cough, it is a symptom, but, just as a persistent cough may lead to actual disease, namely emphysema, so persistent hyperchlorhydria may result in actual disease of the stomach. The prolonged spasmodic contraction of the pylorus may lead to retention of the stomach contents, and, later, to dilatation. But there is a further consideration, namely, the effect of excessive acid and pepsin on the mucous membrane, not only of the stomach but also of

the first two inches of the duodenum, which are also exposed to their influence.

Why is it that the mucous membrane of the healthy stomach is not digested? Because it contains an anti-pepsin which neutralizes the local power of the peptic juice. In the presence, however, of excessive acid and pepsin, this resistance of the anti-pepsin becomes, in some cases, insufficient, with the result that the stomach wall is, in part, digested away, and an ulcer of the typical round, punched-out variety is formed. This phenomenon is well exemplified in post-mortem ulceration of the stomach, best of all in a case where a healthy man dies by accident when digestion is at its height. Here the supply of anti-pepsin comes to an end as soon as the circulation stops, while the acid and pepsin go on acting and sometimes eat a hole right through all the coats of the stomach. Another notable point is this:—the strongly alkaline pancreatic juice is poured into the duodenum from the papilla of Vater, situated three to four inches from the pylorus. Above the papilla the reaction is acid; below it the reaction is alkaline. Physiologically, therefore, the duodenum may be divided into two portions, a suprapapillary and an infrapapillary. Embryologically, too, the papilla is the true division mark, for it is here that the liver and the pancreas bud off from the alimentary tube. The suprapapillary portion of the duodenum is the only part of the whole length of the intestine that has an acid reaction due to a mineral acid, and it is significant that if the records of surgeons, such as the Mayos, Moynihan, Peck and Wilkie are consulted, it is found that practically 100 per cent. of peptic duodenal ulcers occur in this suprapapillary portion which is exposed to acid chyme, while the infrapapillary alkaline portion is practically exempt. It is also noteworthy that peptic ulcer of the jejunum, which is alkaline in reaction, is unknown, except occasionally after gastro-jejunostomy, an operation which admits acid gastric juice directly into the jejunum.

Hence it is probable that, in the living subject, hyperchlorhydria, when excessive and persistent, may cause ulceration of the mucous membrane to which it has access. To borrow an argument from the records of surgery, hyperchlorhydria is a common symptom in chronic appendicitis, and its long persistence in this affection may lead eventually to gastric disease. Several distinguished surgeons have drawn attention to the association of gastric and duodenal ulcer with appendicitis. Professor Sherren, of the London Hospital, found the appendix normal in only nine out of ninety-six cases of gastric and duodenal ulcer; and the Mayos and Moynihan and others have shown that the majority of cases of gastric and duodenal ulcer operated on

by them have been associated with chronic changes in the appendix, such as adhesions or stenosis, the probable sequence of events being: firstly, appendicitis; secondly, hyperchlorhydria; thirdly, ulceration.

I do not wish to suggest, however, that hyperchlorhydria is the invariable cause of ulceration of stomach and duodenum, for it is equally true that ulceration may precede hyperchlorhydria and be the cause of it. And this brings me to the point I wish to emphasize, namely: that hyperchlorhydria is usually a symptom of some latent disease. The diseases of which hyperchlorhydria may be a symptom are chiefly these: (1) Ulcer, gastric or duodenal; (2) Chronic Appendicitis; (3) Gallstones; (4) Renal Calculus; (5) Movable Kidney; (6) Gastrointestinal Atony with Constipation; (7) Chlorosis. Just as a cough may be due to phthisis, pleurisy, a relaxed palate, or even wax in the ear, so hyperchlorhydria may be due to any of the diseases just mentioned. And each of these diseases should be thought of and examined for by the physician before he jumps to the conclusion that the hyperchlorhydria is merely a symptom of an overtaxed nervous system, the result of mental overwork, worry, or fatigue.

The Physiology of Gastroenterostomy is worth a few moments' attention. After that operation, what course does the food take? If a Bismuth meal is given, it is seen to leave the stomach by both openings, nature's and the surgeon's, provided each of these is not markedly stenosed. In experimental operation on cats, where the stomach is normal to begin with, the food tends to take the old route in preference to the new. In a series of twenty-two cases in man, where operation had occurred months or years before, Hartel found that in half the cases, including those in which pyloric stenosis was pronounced, food left by the new opening; in the other half it left by both openings.

What is the effect of gastroenterostomy on the stomach acidity? If hyperchlorhydria is present before operation, as it frequently is in cases selected for gastroenterostomy, the operation reduces the acidity to the normal level. On the other hand, if the acidity is normal or subnormal, no change occurs; if it is normal before operation, it remains normal; if it is subnormal it remains subnormal.

Is the power of digestion and absorption lessened by gastroenterostomy? In non-malignant cases, after gastro-jejunostomy, patients usually become fat and well nourished, and examination of the faeces in such cases goes to show that the amount of unabsorbed fat and protein is very little greater than in the normal individual.

Returning from surgery to more strictly physiological questions it might be of interest to discuss a few points in the *absorption of food stuffs*. To take proteins first.

Proteins are organic substances having a very large molecular weight. Before they can be absorbed by the villi of the small intestine they must be broken up into substances of much smaller molecular weight. This chemical decomposition is the purpose of digestion. In the stomach, proteins acted on by the enzyme pepsin in an acid medium are broken up, through various stages, into peptones. Peptones, though lighter than proteins, are still of too large molecular weight to be absorbed, and so the process is carried to a farther stage in the small intestine. Here, in an alkaline medium, the enzyme trypsin, with the all-important aid of the enzyme erepsin of the intestinal juice, breaks up the peptones into polypeptides and these again into amino-acids; and the amino-acids, being of light molecular weight, can be picked out and absorbed by the columnar cells covering the intestinal villi.

What is an amino-acid? Without wishing to weary the reader with chemistry, let me recall simply what an amino-acid is. An amino-acid is an organic acid in which one of the atoms of hydrogen has been replaced by the group (NH_2). Take a simple organic acid such as acetic acid. Its formula is CH_3COOH . In the CH_3 replace one of the hydrogen atoms by (NH_2) and the formula reads $\text{CH}_2\text{NH}_2\text{COOH}$, or amino-acetic acid. A glance at this formula shows that the molecular weight, in actual figures 75, is as nothing compared with the almost mythical proportions of a protein; and enables an amino-acid to pass through the "intestinal sieve" where a protein would be rejected.

Having been absorbed, then, the amino-acids are promptly rebuilt into tissue proteins, either by the very columnar cells which have absorbed them, or by the liver, and are dealt out according to the needs of the body.

Now pepsin alone, and trypsin alone, in suitable media, can, if given sufficient time, split up protein through all the stages down to the amino-acids, but they would require the greater part of twenty-four hours to do so. Now, as absorption of food takes place almost entirely in the small intestine, and as food takes only five hours to pass from mouth to cæcum, these enzymes, acting alone, would not have time to do their work. It is the important enzyme erepsin of the succus entericus which comes to the rescue, and, acting along with them, enables them to complete their work in the limited time at their disposal.

What proof have we that proteins are absorbed in the form of amino-acids? We know that amino-acids are formed in abundance in the small intestine; that life can be sustained by feeding on amino-

acids obtained by tryptic digestion; and that, during protein digestion, an increase of amino-acids has been demonstrated in the blood, though they appear to circulate as such for only a short time, being rapidly synthesized into blood proteins.

Peptone, as has been said, is not absorbable; therefore when we give to a patient peptonized food, we must not think that we have saved him all the trouble of digestion. We have done only part of the work, and he must complete it. Then, it may be asked, why not save him all the trouble and feed him with amino-acids which he can absorb at once? Because they are bitter and unpleasant, upset the stomach, and cause diarrhoea. They are not normal occupants of the stomach.

The small intestine, then, absorbs proteins in the shape of amino-acids; it also absorbs carbohydrates as sugars, and fat in the form of glycerine and soaps. In fact, all the hard work of absorption is done by the small intestine. The stomach, in normal circumstances, absorbs nothing, not even water. But it is to be noted that many drugs and salts are absorbed by the stomach, and alcohol is very readily absorbed, accounting for the rapidity with which it produces its effects.

In contrast with the hard-working small intestine, the colon is a lazy individual. It absorbs, to some extent, foodstuffs that have escaped the attention of the ileum, but its main useful function is to absorb water. Beyond that it may be regarded as a scene of bacterial riot; so much so that actually one-third of the total weight of dried fæces consists of bacteria. It is not essential to life. Patients may survive and keep up nutrition after most of the colon has been excised, after the establishment of an artificial anus at the cæcum, and after ileo-sigmoidostomy. Contrast this with the fact that if an artificial anus is made in the small intestine even as low as twelve to eighteen inches from the cæcum, the patient starves to death because of the loss of absorptive surface and the want of regulative action of the ileo-cæcal valve.

In one item of therapeutics we ask the lower intestine to work for us, and that is in the administration of nutrient enemata. Nutrient enemata are required but seldom, but when they are employed it is only just that we should present these enemata in such a form that they can be absorbed. The old method of preparing a nutrient enema was to allow *Liquor Pancreaticus* to act on milk for twenty minutes to half an hour. This certainly peptonizes the protein, reduces it to peptones; but for absorption, protein must be still further simplified into amino-acids. Fortunately this is easily accomplished, simply by allowing the *Liquor Pancreaticus* to act on the protein, not for half

an hour, but for twenty-four hours; for by that time amino-acids and not peptones are the chief end-products of tryptic digestion. If, therefore, we wish to give a nutrient enema containing protein, we must, if we are logical, allow artificial pancreatization to go on for twenty-four hours before administering the enema to the patient. Liquor Pancreaticus is procurable as Essence of Diazyme (Fairchild).

The objection may be raised that patients have been kept alive for weeks on ordinary nutrient enema, and weight may have been well sustained at first. But this will happen even if water alone is given, for many of the patients in question have been severely bled beforehand by hæmatemesis and readily absorb water into their half empty blood vessels, just as they do a saline enema. Patients fed for weeks by ordinary nutrient enema are in a fictitious state, possibly appearing well but having little real strength, and every now and then among such patients we find a sudden and unaccountable death.

Except for the water it contains, the ordinary nutrient enema is useless, as far as protein absorption is concerned. Consider the following evidence. When protein is absorbed, the output of nitrogen in the urine is increased, and the nitrogenous output of the urine has therefore been made the test of protein absorption. Laidlaw and Ryffel fed their patients on nutrient enemata and then estimated the output of nitrogen in the urine, and they found that it was only about the same as the output of professional starving men at the same date of starvation. In other words, their patients were being starved. Langdon Brown found that whether he gave his patients enemata of normal saline or peptonized milk, the nitrogen output in the urine was the same. Boyd and Robertson have also shown that the absorption of nitrogenous food-stuff in the ordinary rectal enema is practically nil, for the nitrogen output in the urine did not increase, and in further corroboration they recovered in the rectal washings the peptone they had used.

The next question is:—if the large intestine cannot absorb protein substances in the form of peptones, is it proved that it can absorb them as the small intestine does, in the simpler form of amino-acids? Short and Bywaters have experimented on a number of patients to settle this point. They first fed on milk by the mouth and estimated the nitrogen output in the urine by the Kjeldahl method. Next they fed on salines by the rectum; the nitrogen output naturally fell. Next they fed on ordinary nutrient enema, *i. e.*, milk pancreatised for twenty minutes, but the nitrogen output did not rise because peptone was not being absorbed. Finally they fed on enemata of milk pancreatised for twenty-four hours, and the nitrogen output immediately

rose almost to as high a level as when the patient was being fed on milk by the mouth. In other words, protein, in the form of amino-acids, was being absorbed. It is also of interest to note, in corroboration, that by the same tests synthetic amino-acids were also absorbed by the colon.

So much for the absorption of protein, the conclusion being that protein, pancreatised for twenty-four hours, can be absorbed by the rectum.

The absorption of fat by the colon is more difficult to determine. There are two interesting cases on record which have helped to throw light on this question. In one case the patient had a fistula of the thoracic duct. The patient was fed on nutrient enemata, containing, among other things, pancreatised fats; the discharge from the fistula was afterwards analyzed and it was found that only three to five per cent. of the fat administered per rectum was recovered from the fistula.

The other case was that of a patient in whom the thoracic duct was blocked and in whom a lymphatic vessel had ruptured into the urinary passages so that chyluria was present, most of the fat absorbed by the lacteals after a meal containing fat escaping in the urine. In this patient, when all fats by the mouth were stopped and nutrients containing pancreatised milk administered by the rectum, the chyluria ceased; that is to say, no fat was absorbed into the lacteals and therefore none appeared in the urine. From this evidence it would appear that we can hope for absorption of very little fat from the rectum.

On the other hand, carbohydrates in the form of dextrose can be absorbed. One of the methods of treating severe acidosis, in which vomiting prevents the retention of anything by the stomach, is to give dextrose by the rectum, a 6 per cent. solution in warm, distilled water, two or three pints being administered slowly. Absorption is shown by the fact that the acidosis is cured and the respiratory quotient is increased, owing to the amount of carbon dioxide expired.

When enemata containing both peptone and dextrose are given, and after a suitable time the rectum is washed out and the washings examined, it is found that while the peptone is recovered, practically no sugar is returned in the washings.

There is one point to be noted, lactose, milk sugar, is not absorbed, as far as is known. It does not control acidosis, and, therefore, for example, should not be used per rectum to control severe acidosis in children.

Water, salt, alcohol, especially in the form of brandy and whiskey, and drugs are rapidly absorbed; so that to conclude, the materials for

nutrient enemata at our disposal, on the absorption of which we can depend, are:

- (1) Milk—pancreatized for twenty-four hours—four ounces.
- (2) Dextrose—one dram.
- (3) Alcohol—as brandy or whiskey—four drams.
- (4) Water.
- (5) Salt.

The alcohol may not be necessary, but if it is indicated, it is not only easily absorbed, but is said to aid the absorption of the other constituents. Further, alcohol is a fat sparer, and, as fat cannot be absorbed in any useful amount, alcohol does the next best thing, for it spares the metabolism of fat already in the body.

ENDERMIC VACCINATION AGAINST SMALLPOX.

By WILLIAM S. WALSH, M. D., West Pownal.

Of late several comparatively new methods of vaccination against smallpox have been proposed in order to overcome the ill results not infrequent with the usual scarification and incision methods. Chief among these methods are the so-called endermic,¹ or vaccination by means of multiple punctures, and the intradermic² method. In the latter method, diluted vaccine is introduced hypodermically between the layers of the skin. The first named method, the endermic, has been used exclusively in two hundred eighty vaccinations at the Maine School For Feeble-Minded with results so generally satisfactory as to seemingly warrant their report.

The endermic method of vaccination is performed in the following manner:

1. The site selected for vaccination is gently washed with soap and warm water, and then with alcohol or ether. Scrubbing should be avoided, and is unnecessary unless the skin is very dirty. The skin should not be abraded, nor should the washing be so vigorous as to cause marked erythema. If redness is caused it should be allowed to subside before vaccinating, thus lessening the liability of drawing blood during the operation. The usual site is, of course, about the insertion of the deltoid, though in girls it may be well for social reasons to choose another place, as the leg.

2. When the skin has dried a small drop of vaccine is deposited upon the skin at three points. Each of these points should be at least two inches apart and in triangle formation. The chief object of vaccinating at three points rather than one is that the chances of a "take" are better; possibly, if all three take, the immunity conferred is greater than with one. In infants one or two areas two inches apart may be used. The droplets are placed two inches apart principally to prevent coalescence of the pustules, with the formation of a large sore, in case all three areas "take".

3. The vaccinator, holding his left hand beneath the patient's arm, draws the skin tense. The skin should not be put too much on a stretch else blood is apt to be drawn during the operation. With a sterile needle from ten to fifteen tiny punctures are made through each droplet of vaccine. Each set of punctures should not exceed one-sixth of an inch square. The punctures should not draw blood, but should just go through the upper layers of the skin. If blood is drawn it may not interfere with the operation's success.

The best needle to use, probably, is an ordinary sewing needle of good size. The points supplied with the tubes of vaccine are not quite as suitable. If one wishes, the needle may be fixed in a handle, as a penholder, but we have found it quite convenient to hold it between thumb and index finger. As a rule, we vaccinated twenty-five or more at a time and found it conducive to speed and convenience to sterilize, by boiling, as many needles as there were vaccinations to be done at one time. Needles may be used over again, but have a tendency to lose the evenness of their points after being used more than twice.

After a person has used this method a few times he will soon be able to vaccinate rapidly without drawing blood. We have found that if the operator rests his wrist on the patient's arm and makes the punctures by a wrist movement rather than a free arm one, the chances of drawing blood are lessened.

4. After puncturing, the arm may be immediately wiped with a piece of sterile gauze or cotton and the sleeve pulled down, or the arm may be exposed to the air for a minute or so before being wiped. It has seemed to us that this last method aided good results.

There is no need of applying bandages or dressings of any description, unless use is made of a small square of gauze sewed to that part of the clothing which comes in contact with the area. In private practice it may be well to apply some form of dressing and thus avoid possible parental censure should untoward results occur. Shields are hardly appropriate, and any dressing which retains heat and moisture

is unsuitable and potentially harmful. When pustules are formed, especially if large, several layers of gauze, retained with a narrow strip of adhesive plaster above and below, may be applied.

The usual advice to avoid vaccinating when the patient is ill, noticeably undernourished, suffering from a severe or extensive skin disease, etc., should be heeded, and, except during epidemics, vaccination should not be performed during the summer months.

In typical cases, following vaccination by the endermic method, a small round wheal is noted at each vaccinated area. This subsides rapidly, and nothing further is noted for from five days to a week, though there may be slight redness over each area. The areas which are to take will then swell, noticeably redden, and itch. In a few days the papules will become vesicular, and in a few days more pustular. The pustules are usually small, though quite large ones are encountered. There is some soreness, redness and swelling of the arm, as well as swelling of the axillary glands, but such is usually slight and not marked enough to cause anxiety to physician or patient. The pustules gradually dry up, usually beginning at the center, with scab formation. The scab, when it separates, leaves a small round scar. The time elapsing between vaccination and scab formation is from three to four weeks.

In cases where the vaccination does not take, nothing happens. The areas may be slightly itchy and may redden, but after a few days this disappears. This is what usually happens when the patient has never been successfully vaccinated. If the person has had smallpox or has been successfully vaccinated the areas will in a few days redden, swell, itch slightly, and have the general appearance of "taking". The redness and swelling then rapidly subside. In some instances the swelling goes on to vesicle formation, followed by crust formation inside of a week. Such occurrences are usually deemed immunity reactions.

Of the 280 vaccinations, 174, or 62.11 per cent., were successful. Of the 106 failures, 82, or 77.36 per cent., had typical scars resulting from previous vaccinations. One of the failures had smallpox some years ago. Twenty-three, or 8.21 per cent., had never been successfully vaccinated before and failed on this occasion. Only 36, or 12.85 per cent., among the 174 successes had scars.

While the results of these two hundred eighty vaccinations do not appear, on first sight, very remarkable, the endermic method without doubt possesses certain advantages over the methods usually employed. For one thing, it is apparently as successful, if not more so, as the ordinary methods, and it seems to be, from our experience,

particularly useful in first vaccinations. As may be noted, most of the failures in the series occurred among those who had been vaccinated successfully before. Unfortunately, there are no convenient means for ascertaining when these persons were vaccinated, but it is definitely known that at least nineteen of them were successfully vaccinated in 1912 or later, and it seems probable that others were vaccinated within the period during which vaccination is considered protective. The majority of those who had scars showed the so-called immunity reaction. No attempt has as yet been made to re-vaccinate the failures, so whether the failures were due really to probable immunity or chance remains to be seen. However, it is not at all rare to meet individuals who seem to be particularly resistant to vaccination, no matter how many attempts are made. These instances are probably more frequent among those who have been vaccinated successfully. The intradermal method described by Wright is apparently very successful in these obstinate cases. For all ordinary purposes, and for use by the general practitioner, the endermic method is as satisfactory a method as any.

The endermic method is particularly valuable because of its painlessness and the rapidity with which it may be performed. Practically all of the persons vaccinated regarded the procedure as something interesting. "It doesn't hurt," "It tickles," etc., were common remarks. Those who made objection—not more than a half-dozen—did so through timidity before the operation was begun. In vaccinating children one should use every-day psychology. To grasp a child roughly, or to make a display of the instruments used, is almost certain to cause trouble. If the child is timid it should be talked to kindly and its confidence won. This may seem a small matter, but it is important nevertheless.

Out of the one hundred seventy-four successful vaccinations there were but three arms that showed large ulcers along with noticeable swelling of the arms and forearm. These were not particularly painful, and required no special treatment. About six cases showed slight constitutional symptoms and remained in bed for a day. While there was redness and swelling in practically every case, such was slight and did not interfere with all, save the above cases, going about their usual occupations, if any. The comparative freedom from complications is apparently a marked feature of this method; in this way, at least, it is superior to scarification or incision. Soreness of the arm and axilla was present in practically every case, but it was usually slight. It may be interesting to note that the lower grade children made no complaint at all, nor seemed to be affected for ill in any way.

Those cases which showed constitutional symptoms, and where complaint was made, were all among the higher grade children. Thus it seems that the less the intelligence the greater the obtundation of the senses. Considering the class of children upon whom the vaccinations were done the comparative freedom from complications is noteworthy. In only a few instances were dressings used, and these in cases where the pustules broke, or where the pustules were large and apparently ready to discharge. This meant much saving of time, as well as of expense.

In most cases where the vaccination was successful all three areas "took". If one is using the vaccine supplied in tube points, and, having a number of patients to be vaccinated at the same time, wishes to cut down the expense one area per patient may do, though the chances of a "take" are naturally less.

When one contrasts the size of the scars resulting from the endermic method with those from the usual methods a striking difference is noted. The latter scars are usually quite large and disfiguring. Those resulting from the endermic method are, as a rule, quite small and are not conspicuous.

REFERENCES.

1. De Lanney, E. L. The Army Method of Vaccination.
Military Surgeon, January, 1918.
2. Wright, L. T. Intradermal Vaccination Against Smallpox.
Journal A. M. A., August 24, 1918.

REPORT OF A CASE OF ENCEPHALITIS LETHARGICA.

By JOHN F. SHAW, M. D., F. HERBERT BARTLETT, M. D.,
Central Maine Sanatorium, Fairfield.

History.—R. S., Case No. 1144A. A boy, aged 4 years, was admitted to this institution in the late afternoon of March 31st with the following history: He had had an attack of influenza in November last, being sick in bed ten days, and from which he made an apparently perfect recovery except that he was subject to colds, of which he had several attacks from that time to the date of his present illness. For two days before entrance, he was drowsy and slept most of the time. He was easily aroused, but would soon go to sleep again, even while taking nourishment. When aroused he was irritable, would cry, and complained of headache. Patient was seen by the family physician who also examined patient's mother and referred them both here for pulmonary tuberculosis.

Examination.—Patient was very drowsy, listless, and slept almost constantly after entrance. There was slight rigidity of the neck, the head was tender to firm pressure over the parietal bosses, and when aroused, patient would raise both hands to his head as if to indicate pain. The pupillary and tendon reflexes were normal. Rectal temperature 99, pulse 104. White blood count 10,800. Urine negative.

Clinical Course.—Patient continued drowsy and slept almost constantly. Two days after entrance, April 2nd, because of increased rigidity of the neck and a suggestively positive double Kernig's sign, a lumbar puncture was performed with the following results: The canal was easily entered, the patient was aroused by the insertion of the needle, but immediately fell asleep and remained so during the tap. The fluid was, under slightly increased pressure, clear and colorless, alkaline to litmus, 20 c. c. were obtained, cell count 26 per cu. mm. The cells were principally lymphocytes. A specimen of the fluid was sent to the State Department of Health for examination and the following report returned: No. of cells per cu. mm., 32; Noguchi test for increased globulin strongly positive; Wasserman negative; examination of sediment for organisms, negative; cells principally lymphocytes.

A few minutes after withdrawal of the fluid, patient brightened and appeared perfectly normal for a few minutes, but soon became drowsy and went to sleep again.

April 3rd, another lumbar puncture was done, with practically the same results, except that only 10 c. c. were obtained and the pressure was less.

April 5th, in the afternoon, patient's respiration changed and became of a modified Cheyne-Stokes type, neck was markedly rigid and a positive double Kernig's sign was noted, the pupillary, knee, ankle, and plantar reflexes were normal. After another lumbar puncture, the results of which were as follows:—pressure markedly increased, cell count 64 per cu. mm., cells principally lymphocytes, 30 c. c. of fluid obtained—the respirations again became normal and continued so during the next 36 hours. White blood count 11,600. Urine negative.

April 7th, respiration again modified and another puncture was done—pressure markedly increased, 25 c. c. obtained, lymphocytes 46 per cu. mm., fluid clear and colorless. Following the puncture, respiration became normal, but during the following day became again Cheyne-Stokes in type. On this same day, ptosis of the left eyelid was noted for the first time.

April 9th, respiration still modified in type, ptosis of left lid not

quite as marked, neck not so rigid. Kernig's sign not obtained, internal strabismus and dilatation of left pupil noted.

April 11th, lumbar puncture performed, with results similar to preceding taps, no change in respiration or eye signs following. Ptosis of left lid very marked, strabismus had disappeared, eyes fixed, staring, and apparently not cognizant of objects placed before them. Left pupil was markedly dilated and reacted very sluggishly to light, right pupil normal. From this time on, patient steadily failed and died April 13th. During his illness, patient's rectal temperature varied between 98 A. M. and 101 P. M., pulse between 88 and 120. Because of an inability to keep patient awake sufficiently long to take nourishment, nutrient enemata, which he retained fairly well, had to be given.

April 14th, an autopsy was performed. On opening the cranial cavity, the dura was found to be thickened and tense with the underlying congested brain tissue. Brain was enlarged, soft, increased in weight, filling the cranial cavity, and showed marked hyperemia, both of the surface vessels and those of the brain substance. Subdural space was distended with an increased amount of clear, colorless fluid, ventricles markedly distended with increased fluid. The other body parts were not examined.

MAINE MEDICAL ASSOCIATION.

MEETING OF THE HOUSE OF DELEGATES.

The House of Delegates will meet at 8.00 P. M., on Tuesday evening, in the parlor of the Columbia Hotel, and at such other times as may be necessary, subject to the call of the president.

MEETING OF THE COUNCIL.

The Council will meet subject to announcement by the president.

PROGRAM.

WEDNESDAY, JUNE 18.

10.00 A. M.

Call to Order by the President,

G. H. COOMBS, Waldoboro

Invocation,

ASHLEY DAY LEAVITT, D. D.

Introduction of Visiting Delegates.

"The Control of Venereal Disease in Maine,"

H. E. HITCHCOCK, Augusta,

A. A. Surgeon, U. S. P. H. S., Division Director

Discussion opened by L. D. Bristol, Commissioner, Augusta; G. A. Phillips, Bar Harbor

"Report of Necrologist,"

J. A. SPALDING, Portland

2.00 P. M. Sharp.

President's Address,

G. H. COOMBS, Waldoboro

"The Development and Operation of Our Base Hospitals,"

W. E. KERSHNER, Bath

Medical Clinic at the Children's Hospital, corner of High and Danforth streets, under the direction of E. W. Gehring, visiting physician.

At this clinic, R. C. Cabot, of Boston, will demonstrate interesting medical conditions among adults and children.

8.15 P. M. In Frye Hall.

Public Address—"Social Service in Hospitals,"

R. C. CABOT, Boston

Members of the Association, their wives and any other interested persons are most cordially invited to be present.

THURSDAY, JUNE 19.

9.00 A. M.

"Reflex Symptoms of the Upper Abdomen Caused by Chronic Appendicitis,"

R. W. WAKEFIELD, Bar Harbor

"Treatment of Pneumonia as Suggested by Recent Clinical and Bacteriological Findings,"

L. L. POWELL, Saco

"How to Reduce the Mortality Rate in Cancer,"

W. M. SPEAR, Rockland

1.30 P. M. Sharp.

"What Lessons Have Been Taught the Medical Profession by its Experiences in the Recent War,"

CHANNING FROTHINGHAM, Boston,

Visiting Physician to the Peter Bent Brigham Hospital

"Medical Examiner Service in Massachusetts,"

TIMOTHY LEARY, Boston,

Professor, Bacteriology and Pathology, Tufts College Medical School;
Medical Examiner for Suffolk County.

Discussion opened by the Hon. Scott Wilson, Associate Justice, Supreme Judicial Court

"The Medical World after the World War,"

CHARLES E. BANKS, Washington, D. C.,

Assistant Surgeon-General, U. S. P. H. S.; Chief Medical Adviser,
War Risk Insurance Bureau.

Report of House of Delegates.

Report of Council.

Election of President.

SHORE DINNER.

Place to be announced later. Members of the Association and visiting physicians are asked to be the guests of the Cumberland County Medical Society on this occasion.

NOTICES.

It is respectfully requested that there be no smoking in the main hall.

The attention of members is called to the rule of the Association that "no paper shall occupy more than twenty minutes in its delivery; and no member shall speak longer than five minutes, nor oftener than once, except by unanimous consent."

Those members who hope to attend the shore dinner must communicate to that effect with the Entertainment Committee, of which A. H. Little is Chairman, at the earliest possible moment.

Necrology.

HARRY EVERETT GRIBBIN,

Rockland, 1875-1918.

Every city in Maine has its favorite specialist, a man of good



H. E. Gribbin

education for a foundation, and of good standing in the community, and for whose advice and treatment the people are glad to pay. Amongst such medical men of such a reputation was the late Dr. Gribbin, who passed away from the scenes of his labors at the early age of 43, on Sunday, December 11, 1918, from pneumonia.

Born in Portland, May 8, 1875, the son of Benjamin and Delia Morse Gribbin, the boy was educated in the best of schools obtainable; was a graduate of the Portland High School in 1892, proceeded thence to Bowdoin, where he obtained his academic degree in 1897, and in 1901, at the Medical School of Maine, he obtained his degree in medicine, offering for consideration as proof of his ability a thesis on "Uræmia."

He was next an interne at the Maine Eye and Ear Infirmary for two years, and after further post-graduate studies he settled in Augusta as a specialist in diseases of the eye, ear, nose and throat. He remained there four years, with a gradually increasing practice, but then there opened to him a better and an unopposed practice in the City of Rockland. There he labored assiduously for fourteen years, and won an excellent practice and the esteem of his fellow citizens. He was eye and ear surgeon to the Knox County Hospital from its foundation. He belonged to the County Society, State and American Medical Associations, and was a very efficient secretary of the County Society for several years. He wrote one good paper on the "Nasal Sinuses," but otherwise was not a frequent writer of papers, nor did he take much share in medical discussions. He served on the School Board of Rockland and did good service. During his college life he was much devoted to athletics, and never lost in them his keen interest.

He married Miss Alice Cleaves, of Cambridge, Mass., who, with two children, survive him. During his own last illness, his wife and children were so seriously ill with influenza that they were not informed, until all was over, of the death of the husband and father.

JOHN WATSON SAWYER.

Dexter, 1865-1919.

If ever there was a driver in medicine it was the late Dr. Sawyer, of Dexter, for from sunrise to sunset, and often till late at night, he was busy in one way or another with his cases in town and country, or in town or financial or political affairs. From this disposition to drive business, to the exclusion of needed rest, we owe the too early death, at the age of 54, of a valuable member of the Penobscot County Medical Society and of the State Medical Association.

Dr. Sawyer, the son of Harrison Harlow and Ann Atwood Sawyer, was born in Monmouth, July 7, 1865. His father dying early, he was left under the care of his mother, who saw that he had a good education at Monmouth Academy and at the High School in Gardiner. He taught awhile and then studied medicine at the Bowdoin Medical

School, where he obtained his diploma in 1894, offering for discussion a thesis entitled "De Obligatione Doctoris ad Communitatem," a readable paper on the duties of a physician to the people amongst whom he settles for practice.

He settled at once in Dexter, and married, September 12, 1906, Miss Mary Field Eaton, of that town, who now survives him. Following out the ideas of his thesis, he became superintendent of the public schools for five years, went into politics to obtain at the State Legislature better public health for the rural populations, was a member of the electoral convention in the Presidential campaign of 1912, obtained monetary influence so as to become a trustee of the local Trust Company, and generally proved himself a good citizen.

During the present war he served on the local draft board, examined most of the men for the 3d Maine, and although he knew that he was overtaxing his strength, he continued his work and drove through to the end. In the middle of December he was taken down with influenza, pneumonia followed later on, and on Wednesday, January 22, 1919, his work was done. His life was really sacrificed by too much work for others.

ALBERT WILSON NASH,

Vinal Haven.

After ten weeks of influenza illness, caught in his place of practice whilst attending numerous patients afflicted with that epidemic, pneumonia established itself in the left lung, and Dr. Nash ultimately made his way, as most convenient to him, to the Massachusetts General Hospital in Boston, where an operation for empyema was well performed. Pneumonia, however, crossed over after the operation into the right lung, he failed to rally, and died December 3rd, 1918. He suffered greatly during his last illness, but remained courageous and hopeful, and continued forgetful of self up to the last day of his own life, to encourage his wife that he would soon be on his feet again.

Dr. Nash was born in Nobleborough, March 11, 1871, and was graduated at the Medical School of Maine, presenting a thesis on "The Treatment of Simple Fractures." After obtaining his degree he practiced in Cooper's Mills (Whitefield) for a year, and then moved into the exceedingly busy country practice of the town of Jefferson, Maine. He continued there for about twenty years of very active practice, but was glad when, in June of 1918, he saw a chance to sell out and to remove to the quieter centre of Vinal Haven, where there was less traveling about to be done. And yet we note with sorrow that in this new place of practice, in a very few months, he contracted the disease which ended his useful life. He was a quiet man, devoted to his practice, and to his family when patients did not prevent him, was a good, square man to deal with, and was liked by his clientage in whatever place he practiced. On January 15, 1912, Dr. Nash married Miss Mabel Elberta Embleton, a graduate nurse from the Maine General Hospital, and is survived by her and a daughter of six years of age.

JOURNAL OF MAINE MEDICAL ASSOCIATION

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Editorial Comment.

CIRCULAR FOR REGISTRATION OF PHYSICIANS.

The Council of National Defense has sent out a new circular for the purpose of registering all physicians who do not already belong to the Medical Reserve Corps, U. S. A., or to the Volunteer Medical Service Corps. The intention of this is to obtain exact information concerning the origin, standing and ability of every physician in the nation, for permanent reference in the Surgeon General's Library at Washington. It is to be hoped that every physician to whom the call applies will do his duty and do it at once, upon arrival of the circular in question. Promptness and accuracy mean much in settling the permanent status and value to the nation of every physician, no matter how young, or how old, or how defective in body. Let each man and each woman see to it that these circulars are attended to at once after arrival, and above all, let those who fail to receive the circular send for one at once to the Medical Section of the Council of National Defense in Washington.

NATIONAL CONFERENCE FOR SOCIAL WORK.

To Members Attending the A. M. A. Meeting at Atlantic City:

We have been requested to say a few words concerning the Convention for Social Work, to be held at Atlantic City about the time of

the meeting of the A. M. A., and gladly give space to a brief statement of the program proposed. We trust that members of our Association attending early the meeting of the A. M. A. will join in and listen, or even say a word of encouragement.

The claim of public health enthusiasts, that questions of physical well-being affect every other department of life, finds unusual exemplification in the program offered for 1919 of the National Conference of Social Work, to be held at Atlantic City, June 1-8. The extensive outline of the week's meeting has just been issued, and "Health and the Standard of Living" has been chosen as the general theme of the conference division on health. Dr. Winslow, of Yale, has arranged for a symposium on the relationship of sickness and poverty, and under his leadership seven applications of the general theme, "Health and the Standard of Living," will be successively presented—housing, family food supply, tuberculosis, medical and nursing care, infant mortality, industrial hazards, and venereal diseases.

Dr. Welch, of Baltimore, and Dr. L. Emmett Holt, of New York, will take part in the discussion of the new health program for school children, which is one of the several discussions to occur under other divisions than the one on health. Amongst other topics may be noted illegitimacy, the day nursery, the girl problem, public aid to mothers, the handicapped soldier, state care of mental diseases, and health insurance.

Unusual emphasis on health problems will be natural, considering that the A. M. A. meets in Atlantic City the week following; but the more important discussions of the social work meeting, from the standpoint of physicians, are expected to occur at the end of the week, for the convenience of physicians early attending the meeting of the A. M. A.

The Physicians' and Surgeons' Adjusting Association, of Kansas City, wishes to call the attention of physicians in this field to the fact that they do collect old accounts. This JOURNAL has accepted their advertisement, which will be found on another page of this issue, and any business transacted with this company will no doubt be entirely satisfactory to those who have dealings with them.

FOR SALE

As the owner has installed a Snooks X-ray machine he desires to sell the Static machine which he now uses. It is in very good repair and can be run by either water motor or by hand. Will sell very cheap. Address this Journal.

As stated in the circular memoranda for Editors of Medical Publications, issued by the Surgeon General's Office on March 27th and May 22d, 1918, it is required by paragraph 423, Manual of the Medical Department, that all medical manuscripts by medical officers, U. S. Army, intended for publication shall be first submitted to the Surgeon General's Office, Washington, D. C., for approval. This regulation, which has been very courteously complied with to date, is still in force as far as medical officers on active duty are concerned. In the case of medical officers recently retired from active duty it is requested, as a courtesy to the Surgeon General and in aid of assembling material for the Medical History of the war, that all medical manuscripts based upon military or official records, or upon military experience during the war, be submitted, as heretofore, to the Secretary, Board of Publications, Surgeon General's Office, Washington, D. C., for record and approval, and that such MSS be accompanied by a carbon copy. Upon approval, the original copy will be forwarded to the journal designated, for publication, and the carbon will be filed in the records of the Medical History of the War.

For The Surgeon General:
(Signed) C. R. DARNALL,
*Colonel, Medical Corps, U. S. A.,
Executive Officer.*

UNITED STATES CIVIL SERVICE EXAMINATION.

ASSISTANT TO MEDICAL DIRECTOR,
(MALE), \$2,000.
June 3, 1919.

The United States Civil Service Commission announces an open com-


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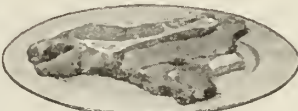
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Per 1000 Calories

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Chicago

(3075)

petitive examination for assistant to medical director, for men only. A vacancy in the United States Employees' Compensation Commission at \$2,000 a year, and vacancies in positions requiring similar qualifications at this or higher or lower salaries, will be filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

CONSULTING PHYSIOLOGIST (MALE),

June 3, 1919.

The United States Civil Service Commission announces an open competitive examination for consulting physiologist, for men only. A vacancy in the Bureau of Mines, Washington, D. C., at \$10 per diem when employed, and future vacancies requiring similar qualifications at this or higher or lower rates of pay, will be filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion.

ASSISTANT EPIDEMIOLOGIST (MALE), \$2,000-\$2,500,

June 3, 1919.

The United States Civil Service Commission announces an open competitive examination for assistant epidemiologist, for men only. Vacancies in the Public Health Service at \$2,000 to \$2,500 a year, and in positions requiring similar qualifications at these or higher or lower salaries, will be filled from this examination, unless it is found in the interest of the service to fill any vacancy by reinstatement, transfer, or promotion. Certification to fill the higher-salaried positions will be made from those attaining the highest average percentages in the examination.

The United States Interdepartmental Social Hygiene Board, through its Executive Secretary, Dr. T. A. Storey, 1800 Virginia Avenue, N. W., Washington, D. C., announces the following appropriations from the Scientific Research Fund of the Board:

Notices.

LELAND STANFORD JUNIOR UNIVERSITY MEDICAL SCHOOL.

- (1) "Investigation into more effective treatment in acute and chronic gonorrhea," under the direction of R. L. Rigdon, M. D., Clinical Professor of Genito-urinary Surgery, and A. B. Spaulding, M. D., Professor of Obstetrics and Gynecology \$2,300
- (2) "The permeability of the meninges to anti-syphilitic drugs—an attempt to increase their permeability," under the direction of H. G. Mehrtens, M. D., Clinical Professor of Neurology 2,300

- (3) "Investigation into more effective methods of treating syphilis," under the direction of H. E. Alderson, M. D., Clinical Professor of Dermatology 2,600
- Total \$7,200

UNIVERSITY OF MICHIGAN, COLLEGE OF MEDICINE AND SURGERY.

- (1) "A research for an improved method of demonstrating the spirochaeta pallida in human tissues," under the direction of A. S. Warthin, M. D., Professor of Pathology \$6,000

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Extract from Contract

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Settlements Made Monthly

DR. H. A. DUEMLING, Fort Wayne, Indiana, says: "I unhesitatingly recommend your Collection Service to my co-workers in the Medical Fraternity." (Grand total collection made for Dr. Duemling to February 20, 1919, amounts to \$1,759.50.)

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Also Pettijohn's Flour — 75 per cent fine patent flour, 25 per cent bran. Use like Graham flour in any recipe.

(3073)

U. S. Federal Trade Commission Dismisses Complaint Filed against the Victor Electric Corporation Last June.

At a regular session of the United States Federal Trade Commission, held in Washington, D. C., March 10, 1919, the complaint against the Victor Electric Corporation was ordered dismissed and discontinued. We congratulate the officers and members of the Victor organization on this vindication.

The personnel of the Victor organization is largely made up of pioneer workers in the X-ray and physical therapy field, and we have always believed that these men (who are directing the policies of the Victor Electric Corporation) have been actuated by a desire to elevate rather than to lower the standard of business ethics in their field.

The Victor Corporation is to be congratulated upon having had the opportunity of having the government searchlight turned upon its activities, and the clean bill of health which the corporation has received should be an inspiration to its officers to continue to be guided by those ideals which should be kept in constant view by all who are engaged in an industry so closely allied to medical science.

YORK COUNTY MEDICAL SOCIETY.

The 96th quarterly meeting of this Society was held in the Town Hall in Sanford, Thursday, April 10th.

The morning session was opened at 10.30, Dr. Ansel S. Davis, of Springvale, presiding. Having properly disposed of several matters of routine business, a recess was taken for dinner, which was enjoyed at Hotel Sanford.

The afternoon session was opened at 2.00 o'clock, and Dr. H. E. Thompson, of Augusta, director and pathologist of the division of diagnostic laboratories, Maine State Department of Health, gave a comprehensive and instructive address relative to the various lines of work done in that department. Dr. Thompson was given a rising vote of thanks.

The following physicians were present: H. E. Thompson, Augusta; A. S. Davis, F. A. Bragdon, Springvale; W. H. Kelly, C. W. Blagdon, H. D. Ross, A. C. Lamoureaux, R. A. Goss, Sanford; S. B. Marshall, Alfred; P. H. Abbott, South Waterboro; J. W. Gordon, Ogunquit; H. L. Prescott, Kennebunkport; C. F. Kendall, A. C. Maynard, Biddeford; J. A. Randall, Old Orchard.

A. L. JONES, *Secretary*.

PERSONAL NEWS AND NOTES.

Major C. F. Kendall has returned from France, where he has been stationed since last summer, and has resumed practice in Biddeford.

Captain Paul S. Hill has returned from service overseas and resumed practice in Saco and Biddeford.

During the past month, Lieut.-Col. T. J. Burrage, Portland, Major C. F. Kendall, Biddeford, Capt. P. W. Davis, Portland, and Lieutenants L. F. Hall, Lewiston, H. D. McNeil, Bangor, H. W. Stanwood, Rumford, and J. M. Sturtevant, Dixfield, have been released from U. S. Service.



Metatarsalgia and Callouses Caused by Weakened Transverse Arch

This condition is recognized by depression of the Transverse Arch anteriorly or at the base of the Metatarsal bones. The dome-like arching is obliterated and painful callosities or corns form over the depressed Metatarsal heads. The foot broadens, the toes become dorsal flexed. Bunions appear at the First and Fifth Metatarso-Phalangeal articulations. Digital nerves become impinged and severe cramp-like pains are experienced through the toes. This is described by Whitman as Morton's Toe.

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Correspondence.

AUGUSTA, ME., April 12, 1919.

DR. G. H. COOMBS,
Waldoboro, Maine.

My dear Dr. Coombs:—Owing to the difficulty in handling material for the JOURNAL of the Maine Medical Association, I am going to outline in a letter to you the scheme which Dr. Sawyer, of Fort Fairfield, Dr. Hardy and I had in mind for a medical practice act.

We had in mind that it would raise the standard of medical examinations and make them more authoritative in their results if the Board of Registration in Medicine should be made up of specialists in the lines in which the examinations are conducted. A physician selected for the position simply on the requirements that he shall have practiced medicine in Maine for a given term of years will rarely turn out to be an expert in physiology, or chemistry or any of the other subjects in which the examinations are conducted. This makes the examination, therefore, really less inquisitive than those given the graduates of our first class medical schools. If, on the other hand, the Board were chosen from men expert in their special lines, as, for instance, those teaching the subjects in state institutions of collegiate grade, this objection would be met. Many of the subjects, such as the two I have mentioned, physiology and chemistry, would allow a choice of examiners from a large number of institutions in the State. It is, of course, probable that the examiners in such subjects as anatomy and surgery would have to be selected from the Medical School of Maine. This at once raises a question.

One of the objects of having such a Board as I have outlined is that under it members of any medical sect found competent to pass the requirements of this Board would be registered and allowed to practice their own therapeutics. Opposition might arise from some of these sects to the change suggested on the ground that an examiner who necessarily was chosen from the Medical School of Maine might not be fair in his examinations to the various sects. This objection, however, is groundless, as under the present system of examination, the examiners do not know from whom the papers come, using only a numeral to identify the papers.

One of our main objects in offering this scheme was that, although the osteopaths are for the time being cared for by the recent act establishing for them a Board of Examiners, there are countless other schools of practice which are demanding, with more or less justice, similar privileges. Many of them are demanding further all the duties and responsibilities of physicians. It was our feeling that the general opinion of the profession has been slowly shifting from the conception that any hard and fast rule with regard to therapeutics can be laid down, and that any practitioner who shows sufficient training in the fundamentals should be permitted to select the form of treatment which he feels is adapted to the case in hand. Such a Board as we describe could make certain that every candidate had an adequate knowledge of the action of drugs by making a thorough examination

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of his knowledge of toxicology. His acquaintance with serum therapy would be assured by the examination in pathology and bacteriology.

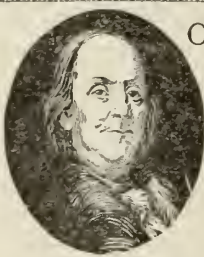
After outlining our scheme with more or less definiteness, we ascertain that under a similar act, the State of Illinois has been conducting examinations, not only in medicine and surgery, but also other subjects, such as law. We feel that the time is ripe to take some such action in this State and hope that the matter will be brought at once to the attention of the society.

Cordially yours,

S. J. BEACH.

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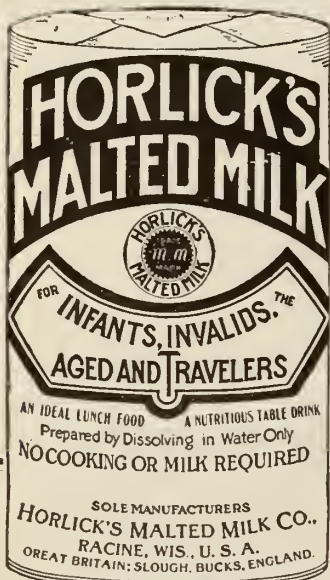
Water,	87.22	89.04
Protein,	2.01	2.12
Fat,	3.74	2.06
Carbohydrates,	6.73	6.32
Mineral,	.30	.46


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Fourth—That vaccination against all three infections does definitely protect against all three.

Fifth—That the protection conferred and the results of agglutination tests, are identically the same whether the individual is immunized against each organism separately or whether the vaccines are given in combination.

Sixth—That the “Non-Specific-Reaction” of Typhoid vaccination is of no avail as a protection against the closely allied Paratyphoid infections.

Of course it is not always safe to reason from analogy. On the other hand is it not well to preserve the open mind and consider if there may not be merit in combinations of vaccines other than Typhoid-Paratyphoid, even though the immunizing response is less distinct and of shorter duration?

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Maine Medical Association meets at Portland, June 18-19, 1919

THE JOURNAL



Maine Medical Association.

The Official Organ of the State and County Medical Societies.

VOL. IX, No. 11

JUNE, 1919.

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Second District,	E. V. Call, Lewiston,	" " "
Third District,	B. F. Barker, Bath,	" " 1920.
Fourth District,	Oliver W. Turner, Augusta,	" " "
Fifth District,	W. N. Miner, Calais,	" " 1919.
Sixth District,	C. H. Burgess, Bangor,	" " "

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Washington,	A. L. Smith, Machias,	H. B. Mason, Calais.
York,	A. T. Davis, Springvale,	A. L. Jones, Old Orchard.

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II
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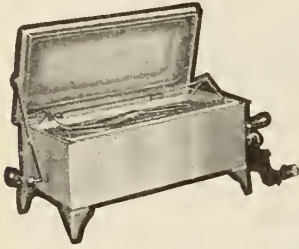
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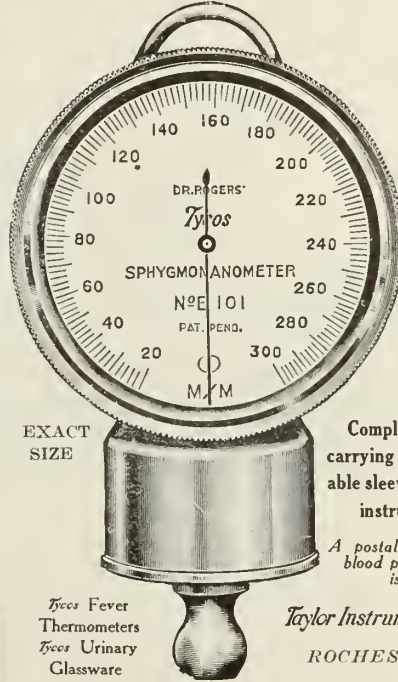
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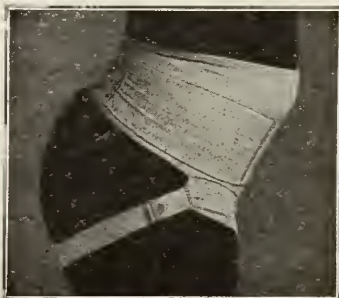
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*CONSERVATION OF VISION.

By DR. JAMES A. SPALDING, Portland.

Conservation of vision, or the care of the eyes, is an important division of Public Health, and one in which all should be interested, although few really are. A committee for every State in the Union has had this subject under constant care for years, and many lectures concerning it have been delivered throughout the nation. The encouragement which the speakers have received has been small, and in spite of their efforts only slight advance has been made in interesting the people. The women of Maine, who might have been expected to do their share in the good work, have been sadly negligent in following out the points suggested by lecturers. I took, for instance, the trouble to attend an annual convention of the Women's Literary Union at Presque Isle, and to mention the points on which lecturers would speak, gratuitously, but from the hundred clubs in Maine there were but two invitations. Once I met an audience of four women and one man, but not wishing to speak before so few, I asked if there were children in the school building in which the lecture was to be given. I was informed that the building was full of them, so they were at once invited to fill the hall, when I thereupon spoke offhand, to their amusement and interest. Having completed another year of this work—and it is to be my last—I bring here for final discussion, the care of the eyes, in the form of a paper, with illustrative slides, and leave it as a sort of legacy for other members.

* Read before the annual meeting of the Association, June, 1918.

The conservation of vision begins before the child is born, by eugenic marriages. A syphilitic will probably beget syphilitic children, affected with keratitis or iritis, ending in blindness for life. Humanity will, in time, fill the world with healthy children, but not until the syphilitic and the feeble-minded, especially feeble-minded girls, are prevented from begetting or giving birth to puny infants.

When a child is expected into the world, care of the eyes begins with disinfection of the birth canal of the mother, never to be postponed or neglected. When the child is born and washed, the eyes must be sterilized by silver nitrate or its salts. Into the need of this, or the way of doing it, I may not enter, for it is plain and simple to everybody. It is a duty to the child and the midwife and the physician. A midwife who neglected this preventive has been cast in \$2,500 damages in this country, and a physician is likewise liable. Whether silver nitrate or silver salts are the better preventive, is disputable, but of one thing we are sure, that silver nitrate keeps forever, and does its work forever, whilst the silver salts must be freshly made in order to do good preventive work. For that reason only, silver nitrate is to be preferred in the hands of the physician or nurse or even midwife, if the physician is not on hand in season.

Sometimes, in spite of prevention, ophthalmia occurs and the treatment is ice and silver. The ice should not be continued too long. The silver nitrate can be used once a day, and the silver salts oftener. For steady treatment of baby's sore eyes the salts in the hands of nurses or of the family are easier to work with, and save the physician much anxious attendance. Nurses and midwives should be faithfully instructed concerning this disease, and made to realize their responsibility, for often they may have cases to which physicians are not even called.

A side issue in conservation, but worth while recalling, is occasional injury to the eyes from slipping of the obstetric forceps. Instances of injury to the cornea, and even of evulsion of an eye, are by no means uncommon from such a curious and unexpected cause. For that one reason, at all events, the careful physician will use caution in applying the forceps on needed occasions.

After the child is born and the eyes are healthy, they should be cared for by shielding them from bright light at home and out of doors. Veils or the carriage top should protect the eyes from direct sunlight. As the child begins to notice objects closer at hand, a cross-eye may develop, and is to be watched for in every child. If observed, the sight of the eyes should be tested as soon as the child is old enough, bearing in mind this important fact, that cross-eye is due to the sight

of one eye being better than that of the other. In other words, a child that squints is on the road to become a person with but one eye, on its way through the world. For that reason lenses should be fitted and worn early, stereoscopic pictures given for daily exercises, and later on, after atropine treatment, an operation may be done.

The operation for strabismus has gone through so many changes, advancement tucking of tendons, division of one muscle, division of two or more, and so on, that there are nowadays, as it were, specialists in such operations, although their results do not seem much better than when division of one muscle, on one eye, and then of its fellow, on the other, were performed.

When children begin to read at home the light should be good. That means that every room in which reading is done should be lit from the table for the work to be seen, whilst additionally the room itself should be lit by a lamp from the ceiling. The light should come from the left, and a little above the work to be seen. Books should be well printed and spaced. Many books have good type, but the lines are too close together. Shiny paper should be prohibited because it wearies the eye by the reflection and is harder to read than when soft, dead paper is used. Try this simple test. Hold a page of shiny paper before your eyes, and put the type in a position so as to be clearly seen, and then turn it a shade this way or that, and the type which you could at first see plainly has disappeared, and you need to make an effort to see it. Books and maps should not lay flat on the table for study or reading, but should be propped up a bit, and great care should be had that the seat for the child is high enough to lift the eyes above the reading work to be done. If this is not seen to, short-sightedness will occur and be a life-long misery. Children should not be allowed to read in the twilight, nor too long at a time during the formative age. Half an hour is long enough for anybody to use the eyes for close work without a change being made. The eyes can give good service if reading is alternated with writing, or piano playing, or knitting, and so on.

During this formative age, when the eye, like the body, is changing its shape, it is a good idea that the sight should be tested in the schools, and there has been no more benevolent law passed than the yearly eyesight testings in the schools for every child. Although it is well done, it remains much of a burden on the teachers, and physicians in every town ought to volunteer to do some of this work themselves.

Before finishing off with home use and care of the eyes something has to be said concerning the lighting of houses, which in many of them is practically ruined by dark wall papers or hard-oil painted

walls. It should be remembered that all colors absorb light and reduce the amount occurring in any room spaces. Even white paper absorbs some percentage, whilst the reds and chocolate-colored walls affected by some people for dining rooms, cut off fully two-thirds of the light let in by windows or used by artificial means. Electric light as we now have it is the best so far invented, and when we have the "Crooke's" ideal of glass, for shades, fully utilized, further improvements will be about impossible.

Here now comes the time to speak of accidents occurring to the eyes of children, the number and variety of which is wonderful.

First in the list comes those inflicted with scissors and knives left in the hands of children so thoughtlessly by their parents. A refractory shoe knot demands undoing. The point of a scissors is inserted within it, and then pulled toward the face. It slips and an eye is injured. A knife is used for whittling and it is pulled toward the child; it slips and an eye is injured and disfigured for life. A child has a napkin pinned around its neck; another child struggles for the napkin, which is finally pulled off over the head of the child wearing it, and the pin holding it in place is pulled against the eye with ruinous results.

Children have given to them tip-cats, India rubber arrow guns, bean blowers, putty blowers, and such instruments, and with them they practice on other children and eyes are lost. A fork is given to a child at its first sitting at the eating table with its parents, and in its ignorance of its use it goes the wrong way from the slippery dish and so ends the sight of an eye. A curious child wants to know what is inside of a golf ball, and learns to its sorrow that the inside is filled with an acid, which flies into an eye with blinding effects. Boys and girls are sent to chop a bit of wood for the fire, and laying it against a log they split it across, and the splinter hits the eyes. Every child should be taught with cutting instruments to cut away from themselves, and in splitting wood to cleave it lengthwise, and not crosswise.

Here is an unexpected injury worth while mentioning, because it cost the owner of the roll of barbed wire some thousands in damages. A roll of wire was resting in front of a shop and a boy had the curiosity to try to move it, and when it did move the end flew up and an eye was injured so seriously that it had to be removed. So, too, in the country farmers and farmers' children have injured eyes from barbed wire fences.

There is a sort of reel attached to eye lens chains, to pull them in after the owner has been using the lenses, and such a reel has often wound up too rapidly and hurled the lenses against the eye with deleterious effect. This is an apparatus to be avoided.

It is not long since that a child was wearing around her neck a chain of burdock burrs, hitched together with the barbs, and when another child tried to pull this off an eye was injured seriously. I know a boy who washed his face in the foam of tar soap and injured his eyes and another who quarrelled with another boy for the ownership of a brush with which to rub lime on a fence, and when the squabble was ended the attacking boy had lost an eye from a lime burn.

Household chemicals, such as water of ammonia, carbolic acid, oxalic acid, and the like, although always kept on shelves, should not be so high up against the wall as to endanger the eyes by the corks falling out in lifting down and the contents falling over the face. Many an eye has been injured by hitting the orbit against a door ajar, in the dark, or in bending over in the dark and hitting the upright knob of a chair. So, too, in putting on wood in a fireplace, the back of the head may be hit in straightening up and concussion of the skull endanger an eye. I have seen many instances of eye injury from cyclists falling forward on a hard road and injuring the orbit or in people being thrown from horseback with like results. A man bends over to buckle up his arctics after a hearty meal, breaks a blood vessel in the retina, and loses his sight. A boy found a copper cartridge, whittled at it to get out the bullet but the bullet got ahead of him, as the charge exploded and the bullet went one way and the cartridge directly into the eyeball, destroying it *in toto*.

Endless, indeed, are the varieties of injuries to the eyes, and long as is the list, it may be lengthened by one more, in which a sail needle, long, curved and sharp, was pushed not only through the canvas of a sail but into the eye of the woman using it. Knocking the hoop off of a barrel may injure the eyes by the head of the nail flying off violently.

I have gone into the list of injuries to a considerable extent, because many of them are entirely preventable. Moreover, I have mentioned them because no more important question ever comes before a skilled expert than this: Shall I, or shall I not, remove an injured eye to save the sight of the other from sympathetic ophthalmia? In all instances of perforating injuries of an eye a consultation should be held, to protect the patient first, and the reputation of the surgeon later.

Much has been said about the wonders of the magnet in removing foreign bodies from within the eyes and many cases have been reported, but little, however, has been said of the many instances in which the eye has been necessarily removed as a result of the irritation

and infection excited by the operation of extraction itself. Much is, therefore, to be said on both sides of this question still.

I suggest at this point that special care should be made to protect children from injuries of the various sorts already mentioned, as they are likely to occur in pupils of the vocational schools of the present day, to which so many are attracted, or, as some might say, driven by the fashion.

I might, at this point, suggest the minor injuries to the eyes occasionally observed by uncautious students, when etherizing patients, gently opening the eyelids and pressing in between them a finger tip to observe if lack of sensitiveness of the eyes suggests sufficient anesthesia for the impending operation by the surgeon. This is often done, and has been known to result in an abrasion of the cornea, taking a long time to heal, with many relapses.

During childhood much attention should be paid to the teeth, because they are necessary for a happy life, including good digestion from utilizing good teeth to chew the food. Children should be taught early to save every tooth, because one of them holds up the other, and a gap in a set gives a chance later along for another and still another to be lost by loosening and premature decay. Moreover, irregularities, decay and loss of teeth lead to many instances of eye strain, and inflammation also, so that the oculist of today who treats many an inflamed eye without considering the cause as resting solely in the teeth, in defective fillings, in too abundant bridge and crown work, is practicing unsuccessfully for his patients. There is much talk about care of the teeth, and it is not overdone at all, but we see too little of the effect of the loss of a tooth upon the lost support in position to those remaining in the jaws.

Trachoma is a disease which has worked its ravages on the eyes of many people in many nations, but in our part of the country it is rare. Wherever it appears it should be treated as soon as discovered, and warning flags kept floating against its contagiousness through sponges and towels.

It is now time to rest your minds from too long a paper on minutiae of accidents and to turn to the eyes in school, where they have the greater part of their life work to do for an education. During these years the eyes are used longer at a time, more steadily at a time, and during the day more than probably occurs at any other time during the rest of their lives with a vast majority of our people.

Care of the eyes in school is very important and depends first on good light in every room in the school building. Try as hard as you will, it is almost impossible to get the windows built up to the ceiling,

and to limit them to one side of each room. Many desks are too flat. Ink and pencils are rarely black enough. The books may be well printed, but they are spaced too closely together. Blackboards are not of the right material and the marks made upon them are glossy and the lines broken. Examples drawn upon them do not show off well to the eyes, because there is no standard taught of how thick the lines of figures and letters should be. It is not enough for the eyes to draw big figures and write big letters, but the strokes of the letters and figures should be thick enough to be seen at the standard distance of twenty feet and in many school rooms as much as forty feet. Music charts as used in our schools have defects for vision in that they cannot be clearly seen at the average length of a school room.

It is a pity that so many windows are situated in school rooms so that the light falls into the face of the teacher, so that she cannot see the faces and the expressions of the scholars. Many school rooms have windows on one side, which is correct, but the additional light from an end must either shine in the face of scholars or of the teachers. The walls of school rooms should be white, and the blackboards placed opposite the source of greatest light from windows.

Maine ought to have one school for the few children within its borders with extreme degree of shortsightedness. In this way many children, later to become good citizens, would be saved from the sufferings of myopes, with loss of sight, detachment of the retina and other serious affections. In such a school the eyes should be spared all exertion, and education carried on through the ear, largely.

In school, finally, frequent examinations should be made of the throats of children, to discover adenoids and enlarged tonsils, which often lead to affections of the eyes.

Wood alcohol was at one time a vigorous topic for lecturers on conservation, but instances of blindness from its use as a drink, or from contact or inhalation, have diminished largely in the last year from prohibitory laws. But as it is so well known that enormous profits can be made from its sale, many ways are still found to cheat the law, under the names of ginger, white spirits and other fictitious titles. It should, however, always be kept in mind that wood alcohol is a danger to the people, and that constant vigilance is needed in this respect.

Hair dyes may not be used for producing the blackness of the hair as of old, when they led to lead-poisoning, with optic nerve inflammation and loss of sight, but dyes to make the hair yellow are used as much as ever, and are equally dangerous from the present point of view.

Tobacco is smoked more and more frequently than ever since the introduction of cigarettes, but candor and truth compel us to say that loss of sight from any form of tobacco is extremely rare, and oftener due to the side issue of beer and spirits than to nicotine alone.

Patent medicines will always be with us so long as people are on the hunt for health, forgetting that the true medicines against disease are greater care in diet, in clothing and in living in every way. In spite of our protests, however, patent medicines will continue to be used, their inventors and sellers will continue to increase in riches, speculators will never cease to invent newer ones still, and in spite of all that we can say from the point of view of care of the eyes, people will buy patent medicines guaranteed to cure sore eyes and restore weakened sight. It isn't hard to understand how people will test a patent medicine inside their stomachs, but it is beyond credence that they will venture to test patent eye waters within their precious eyes.

Do moving pictures hurt the eyes? Who can say in a short period of having them on hand as a means of amusement? It is only time that will tell. Surely enough it does not look healthy for the bodies, or good for the eyes, to sit for hours in a blackened hall looking at bright, shiny moving images, glancing about uncertainly and glaringly. Yet the eyes stand them and survive. It only proves that the human frame is pretty strong in its foundations, to endure so much hard work.

Does it hurt the eyes to read lying down? Who can tell? Some do it and their eyes continue to do good work. Others detest it and never try it. It does not seem natural or physiological that eyes which were made to look partially upward, a great deal directly forward, and a little downward, should be forced into the unnatural and strained position demanded for reading abed or on a couch. Most people, except the sleepless, will never take up reading when lying down and it will save their eyes much pain and strain.

It is curious to note the fashions in lenses. Once on a time they had to be small, they had to be inconspicuous. Now they go to the opposite extreme and cannot be too big and hideous. These goggles indeed are not modern, for pictures of them on the noses of ladies and patriarchs of the fifteenth century abound in art. The great objection to all circular frames is that in wiping the lenses the axis is likely to be changed, with irritation to the sight and many headaches. A loosened circular lens should be tightened at once.

From two curious points of view, care of the eyes is very important and rarely mentioned. I refer to truancy from school, for one item, and proper rest of the eye after children's diseases.

As for truants, it has long been known that many children do not want to go to school because they have some personal defect. They have a birthmark; they are cross-eyed; they do not hear well; they have a discharge from one ear; and so on with other physical defects. A careful study of eye measurements shows that many children are truants from school because they do not see to read well, or they do not see the sums set on the blackboard. They are ashamed and they play truant. For that reason, and in order to obtain as many good citizens as we can, all truants should be carefully examined concerning their sight, and proper lenses directed to be worn constantly.

It is furthermore well known that various children's diseases, such as the measles, mumps, scarletina, diphtheria, tonsillitis and others, are invariably followed with more or less serious loss of accommodation of the eyes, as well as with occasional inflammations of various structures involving the sight. The law directs that all such children shall be kept out of school for a certain period in order to prevent contagion to other children, and to that law I add the pertinent suggestion that such children should also be kept out of school for a considerable time and not admitted again for studies until their eyesight capacity has been thoroughly tested since their last illness.

The items concerning which a lecturer on conservation of vision could speak if he had the chance number at least eighty, and although in this paper only a few have been mentioned, it is useless to burden an audience with too long a paper, and I will now close by mentioning some accidents to workmen.

When I studied in London many years ago, a man was brought into Moorfield's Eye Hospital with an eye so seriously injured by a piece of steel flying from a gigantic shearer that the eye, by the advice of Sir William Bowman and other great oculists, was at once removed as hopelessly ruined. The man was duly discharged, with urgent warning to utilize a set of protecting goggles for the rest of his laboring life. He scorned the advice, went to work as usual, and whilst I was still a student in the same hospital he was brought in again with his remaining eye so cruelly lacerated that it was removed that same morning. But the man did not improve. He developed symptoms of meningitis and died in the hospital. The post mortem examination revealed a piece of steel which had been driven through the eye and lodged in the meninges, and had killed the poor unfortunate. All this owing to refusal to wear protecting goggles.

That incident has never left my memory, though years have passed since it occurred, and I never fail to urge the wearing of pro-

tectors by every workman in every factory. They still take the chances: they still lose an eye. Even if they save it in its orbit, the sight is defective or lost. I know of no greater thing which a workman's wife can do for the benefit of her husband than to urge him to wear his protecting goggles whenever he goes to work riveting boilers or chopping iron. So, too, for the glare of furnaces, hot mouldings, blau gas weldings, and other brilliant occupations, let the workman wear his protectors. He can do nothing more useful to himself, his wife or his children, than to protect himself in this simple fashion. It is true that sometimes a rare instance has been reported in which the goggles have been smashed upon the workman's face and the eye been slightly injured, but let us think more truly of the worse injury which would have resulted had not the glass broken a part of the force of the blow from the foreign body.*

DR. NORTON: Mr. President, the ophthalmic section of this Association voted to make our President a committee for carrying on this work of conservation of vision in the State of Maine. He asked me to assist him, and I did to the extent of my ability. I lectured in quite a number of places, but I met just the same indifference that the doctor has spoken of. They invited me to lecture before the Literary Union, made up of all the women's clubs, but they did not tell me that the woman's rights advocate—I have forgotten her name, but she lives in the eastern part of the State—was to speak. She did speak, and left me but a few minutes to talk upon this subject. I have lectured at some schools, as well as at Bates College, but there is not that willingness to listen to the subject that there ought to be; people are indifferent. I heard one excuse, one reason for this, that surprised me at the time. A member of the Teachers' Association said that they did not want to hear a lecture on the eye because the teachers knew that they were all abusing their own eyes, and they did not want to be reminded of it too often. That explanation surprised me, but I have no doubt it is true—partly true, at any rate.

In regard to ophthalmia neonatorum, I think that perhaps I differ a little from Dr. Spalding in believing that nitrate of silver is the thing to use, and that argyrol and the others he named are not as powerful. I believe that

* During the reading of the paper the speaker exhibited many slides, amongst which may be mentioned a long series concerning the prevention and treatment of ophthalmia of infants, and injuries inflicted by children upon other children by bean blowers, putty blowers, air guns, and rubber-band arrow slingers. Directly after these, attention was called to a set of slides showing proper illumination of homes and school rooms by daylight and artificial light, and to the appearances to children with defective eyesight of problems on blackboards and of pictures on the walls. The latter state of affairs was then emphasized by showing the same problems and pictures when seen by the same children with properly fitted lenses. The final slides exhibited many protecting goggles, as injured by pieces of flying steel and iron, the latest styles of protecting lenses, and the celebrated Cruise's veil for protecting the eyes in trench fighting of today.

every child, where there is a possibility of infection, should have this prophylactic used. I have seen a good many cases of ophthalmia neonatorum without doubt of gonorrheal origin, among people who called themselves the nicest people in town, so we do not have to go to the slums, necessarily, to find this disease. Dr. Van Slack, of New York, said that in examining the vaginas of women of the poorer class, he found in twenty-five per cent. of the cases the gonococcus. Now this disease may come up at any time, and when it does come up, it is a very serious thing. Here is a little point that may be of interest. I saw more cases in an hour in Berlin than I ever saw in a week in any other city in the world. I believe it is a fact that gonorrhea is endemic in the German empire. My friend, Dr. Hill, of Lewiston, said that he saw twenty-five cases of gonorrheal pustule operated on in Vienne in one day.

In regard to the lighting of schoolhouses, I want to say that I have seen but one schoolhouse in the State of Maine that seemed to me to be properly lighted, and that I did not have an opportunity to examine thoroughly, but it was in the town of Newry, a small town way up in Oxford County. It surprised me very much to see a schoolhouse with no windows on the south, east and west sides whatever, and the north side made up entirely of windows, the blackboards being on the south side. It was a small country schoolhouse, and it seemed marvelous to me that that town alone in the State of Maine has a model schoolhouse.

Referring to what the doctor said in regard to the workmen in machine shops—removing particles—I think that the most of those tools are made by the machinists themselves and ground on the emery wheel, leaving deep scratches that surely will be filled with all the germs known to science; and I have seen a great many machinists who have had foreign bodies removed from their eyes by their brother workmen, who have had serious ulcerations and infection of the eye from that cause, I believe.

Necrology.

CARL DINSMORE GRAY,

1886-1918.

A careful reading of the early papers or graduating theses of young medical men, often proves of psychological value, because from them we obtain a clue to the alternations of their mental points of



CARL DINSMORE GRAY, M. D.

view as they gain in experience. In the case of our comrade, Dr. Carl Gray, we note, for instance, that during his student life he spent some time in a sanatorium for tuberculosis, so that, influenced by his environment, his graduating thesis discussed the treatment of diseases met with there. A few months later he studied cases of syphilis, and was led by them to the investigation of a test for that disease, in the shape of a solution of iodine in chloroform and a solution of phos-

phoric acid, which he found of value when controlled by the test of Wasserman. Finally, after a year in the Eye and Ear Infirmary, his mind veered to the treatment of diseases of the eye and ear, so that when he entered the M. R. C. his knowledge was of distinct value for examining aviators, whom he tested by the thousand. Finally, he had in mind, immediately the war was over, to specialize in diseases of the eye, ear, nose, and throat, a decision which showed how his early ideals concerning tuberculosis and syphilis had vanished before the spirit of practical experience.

Although this prelude tells us much concerning the work which Dr. Gray accomplished in medicine, yet a few facts concerning his place amongst his relations and friends may not come additionally amiss.

Carl Dinsmore Gray, the only child of Kittredge Cram and Elizabeth Dinsmore Gray, was born in Madison, Maine, September 12, 1886, and educated in the local schools and at Kent's Hill Academy. For some years his mind wavered between one aim and another, until in 1911, when he was twenty-five, he decided for medicine as a career. He obtained his degree at the Medical School of Maine in 1915, spending one or two summer vacations at a sanatorium for the tuberculous. Immediately after graduating he was appointed an interne at the Infirmary, and in 1916 he entered the M. R. C. He received his commission as lieutenant on active service in September, 1917, and was ordered to Camp Dix, where he spent the rest of his life, examining recruits for aviation service, in which work his former studies proved of value.

Leaving home in 1917 in apparently perfect health, he fell ill in the following year with heart disease and was honorably discharged. He arrived in Portland December 17, 1918, and was on his way to his home in the trolley, when he was seized with symptoms of a cardiac embolus, and hurried to the Infirmary, but in spite of every care he died on the 19th.

Dr. Gray married July 6, 1917, Miss Marion Gertrude Tukey, who, with an infant daughter, survives him. They will long recall the work for the nation which the husband and father accomplished.

The life of Dr. Gray in this way quickly ended. He had labored diligently in the work to which the nation called him. His is one more instance of physicians killed in the war by overwork, as surely as if they had been stricken by a bullet. The examinations to which he and others of this Association were called were unusual and overwhelming. For what can the average physicians, accustomed to the care of a dozen patients a day, accomplish when, as in the camps, recruits are hurled into their presence and out of it at the rate of a hundred a day. It is

more than many physicians can endure. They pay the penalty by death, reaping only the meager reward of a slender memory from the nation, or perchance in the medical history of the State in which they studied and practiced for a while.

MARTIN HERBERT HOWES, CAPTAIN U. S. M. R. C.,

1890—1919.

The lives of some physicians, members of our Association, have been sacrificed during the war in camps at home just as truly as if they had been lost in active duty overseas. Amongst such tragic in-



MARTIN HERBERT HOWES, M. D.

cidents we reckon the untimely death of our young and promising comrade in medicine, Dr. Howes, assistant professor of pathology and instructor in bacteriology and pharmacology in the Medical School of Maine.

Martin Herbert, the son of the Rev. Martin Stillman and Addie Loomis Howes, was born in Newton Centre, Massachusetts, December 20, 1890, where his father was then officiating as minister of the

Baptist church. As his parents moved from Massachusetts to California, and then to Maine, in fulfilling their national duties, the boy accompanied them, looked with youthful eyes on the scenery of California and Mexico, obtained a rambling education here and there, and finally completed a regular high school course at Mexico, in Maine. He entered Bowdoin in 1909, worked at all sorts of labor to carry him through, and obtained the devoted friendship of Ernest Poole, the novelist and manager of the foreign press bureau in Washington, who helped him with encouraging words and many offers of monetary aid, which were, however, declined, as the boy and his parents wanted him to get his college education by his own exertions.

Howes was academically graduated at Bowdoin in 1913, obtaining a good average standing, and then he decided to study medicine. He followed four years' courses, gave much thought to psychology, studied obstetrics in the Boston Lying-in Hospital, and obtained his doctorate in medicine in 1917, offering for proof of attainment a thesis on "The Treatment of Neurasthenia by Psychotherapy." The idea of his brief and tentative paper was that as a large percentage of people of this nation were of a neurotic nature, it was as well worth while to study the benefits of the treatment of their mental unsettlement by psychotherapy as by medicines. Stating briefly the theories in vogue, he set off their value for psychoanalysis and therapy.

Directly after obtaining his degree, he was appointed an interne at the Maine General Hospital, served for six months, and meanwhile volunteered for the M. R. C., obtaining his commission as lieutenant in February, 1918. Ordered to Fort Oglethorpe in July, the weather proved to be exceedingly hot, and it was plain that only those of the strongest constitution could endure the training demanded. Not long after his arrival he was examined for cause, mitral stenosis was diagnosed, and leave of absence with discharge was recommended. Before either could be obtained work was called for at Fort Moultrie, South Carolina, and he went on at once, but suffered from influenza. Before perfectly well, an outbreak of the same disease at Fort Dade, Florida, was announced, and he was ordered there in his already weakened condition. He broke down completely on the road and had to be carried the last forty miles on a stretcher. Arriving safely, and recovering slightly, he was put in almost entire charge of two hundred cases, and it was the end. He could do no more. He obtained his discharge as Captain, in December, 1918, arrived soon in Brunswick, started off eagerly on his lectures on the 14th, was weary, went home for Christmas to Warner, New Hampshire, where his parents were living, was attacked with influenza again on the 27th, and died there on Sunday, January 6, 1919. His last days were peaceful and religious, as befitted the home-loving boy and his upbringing in religious circles.

About the time of his medical graduation, June 2, 1917, Dr. Howes married Miss Jeannie Hagan Mountfort, of Topsham, who survives him, and he remains deeply mourned by her, as well as by his parents, who with continued grief cannot but daily think of the sacrifice to the national duty of their only and most promising son.

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Editorial Comment.

THE RESIGNATION OF DR. BRISTOL.

We have read with sincere regret the very unexpected notice of the resignation of Dr. L. D. Bristol as Superintendent of the State Board of Health, to take effect on August 1st. Dr. Bristol came to us unheralded, and has from the very beginning of his work organized our new Department of Health into excellent shape, and brought about proof of his ability in the good results already obtained. Everybody knows the obstacles in the path of any new ideas and plans for the benefit of the health of the people as a whole, but we are sure that the people of Maine have every reason to be satisfied and glad that Dr. Bristol has done so finely with the material at his command, and in the short space of less than two years. In saying good-bye to our Health Commissioner let us thank him for the gains accomplished, congratulate him on his new position, and assure him of our sincere respect as a friend, adviser, and official. We are losing a man of value, yet we must hope that his equal may be ultimately found, for the work of carrying interne and steady advances in public health demands a good man at the head of the office. Nor are we to forget the steady current of ungrateful and destructive criticism opposing the best efforts of the entire Board of Health, with never a single word of help or suggestions for improved methods, if possible.

The pamphlets of the State Board of Health, which the JOURNAL

has from time to time too briefly noted, have shown the value of Dr. Bristol, and of his assistants to the State. May they be continued as witnesses of the good work which he and they have so far accomplished, and spur on their successors to renewed public zeal, for there remains much to be done for the health of our people, a vast majority of whom still have no idea of health and sanitation and must be forced into their acceptance by constant example and instruction broadcast in primers and pamphlets on health.

THE DECOMPRESSION OPERATION.

Books and more books and pamphlets in abundance have been and continue to be written concerning the decompression operation. Of this operation a few instances, and indeed a very few, have ever been performed in Maine. It is, therefore, with a view to encourage our chief surgeons to cultivate this valuable procedure that we notice, briefly, a paper by Sharp concerning the technique for the operation, as published by him in an excellent paper in *Surgery, Gynecology and Obstetrics* for April. To the various details we refer our surgical readers, and we emphasize the conclusions particular to this effect.

The operation is one that ought to be done more often than at present, especially in brain tumors, abscesses, injuries and spastic paralysis due to intracranial hemorrhage at birth. The subtemporal method is the ideal, less difficult to perform than others, and exposes an area of the brain most often involved. When done here it does not weaken the skull, so that hernia is no longer to be dreaded. The mortality is low, and patients should not be permitted to go blind or to reach the dangerous stage of medullary compression without a subtemporal compression being early performed.

Maine surgeons should make more careful study of cases calling apparently for the decompression operation, and there are two ways in which they can perfect themselves in the operation. One is by performing it on hospital patients on whose bodies post-mortem operations can be obtained, and secondly, by so perfecting themselves in the steps of the operation that the patients occurring in Maine shall not be slipped out of the State for other bolder or apparently more skillful surgeons to operate upon. Maine has men of signal ability in surgery. They should stand out for better brain surgery whenever opportunity serves. At another opportunity we intend to show the benefits to the State by the compulsory permission for surgeons to do post-mortem examination and operations on all patients dying in hospitals.

TWO STATE BOARD OF HEALTH BULLETINS.

We have received from the State Board of Health its bulletin for January, 1919, on "Rural Methods of Waste Disposal," and the March Bulletin on "The Feeding and Care of the Baby." In each of them we note an admirable method for popular instruction, combined with excellent description and well expressed language. The Bulletin on "Waste Disposal" contains various illustrated descriptions of privies with dry earth pans, water closets and sewage tanks, as well as of other contrivances for the benefit of dwellers in the country from a sanitary point of view. Too long has our agricultural population lived in a life-long condition of perpetual odors, nuisances and filth, and such a pamphlet as this now lying before us and asking for brief notice will do much positively good work toward the improvement of the individual, physically, mentally and morally, for when the excretions of the body are shamefully extruded and abominably neglected to putrefaction, as on many of the farms of today, the individual concerned has a tendency to follow in their trail and to become odorous, abominable and filthy himself. Moreover, the children, by the good examples shown for the disposal of refuse about the schools, as in this bulletin, will extend such instruction back into their homes in due season, and for the ultimate benefit of their parents.

The Bulletin on the "Baby," is another document of promising value, because in its sixty and more pages every young mother will surely find suggestions of value, and many a physician, also will read its pages with positive benefit, for his own instruction as well as for aiding him in his advice to the mother.

It is a wonderful benefit for Maine that we have at last a steadily working, full-time Board of Health, and the JOURNAL intends to notice, even if in a briefer fashion than the good work demands, all that this excellent commission has from time to time opportunity and money to publish. This good work has come along late, but it cannot endure too long now for the benefit of every inhabitant, not forgetting even the physicians of the State.

PUBLIC SERVICE—THE PHYSICIAN'S DUTY.

The professional man generally, and the physician in particular, has come to be looked upon as a public character, owing a direct and peculiar service and duty to the public. He is one of a class of citizens who by education and experience has acquired a bigger, broader point of view than can be attained by the average citizen. His education and training give him an understanding of the interests of groups of people. The average man is accustomed to look to the physician for advice and direction in the extraordinary things of life, the things that are beyond the capabilities and experience of the average individual.

The community today looks to the physician for public service as a part of his job. His standing and influence in the community force the community to look to him for this service. The medical profession has been brought forth from the laboratory and the office and placed in the limelight of public service. We have doctor-mayors, doctor-aldermen, doctor-governors, doctor-congressmen and doctor-senators. The public life which half a century ago was confined almost exclusively to the legal profession now demands the services of all men with the broad point of view which is conferred by a professional education.

In assuming the responsibilities of public service, the physician is not only performing his duty to the community, he is contributing directly to his own personal and professional success. The physician who becomes favorably known to his community through his public service will soon become favorably known for his professional service. By no other means conforming with the ethics of his profession can the physician acquire so wide and so thorough acquaintance with the men and women upon whom his professional success depends as he can by public service.

The physicians of the country have demonstrated their willingness to accept the responsibility of public service during the war period. The self-sacrificing services of the profession as a whole in connection with the formation of the great National Army through the draft, not to speak of the actual field service of the thousands of physicians who served abroad or in the training camps here, demonstrated the public spirit of the profession.

A great opportunity is now before the physician in his character of a public man. The American people are seeking to perpetuate the habit of thrift acquired under the stress and strain of the war period.

The success of this movement means a strong, self-reliant American people, independent and able to care for themselves. It means people prepared for the rainy day of adversity or prepared to take advantage of the opportunity which is constantly recurring in American life. It means a better level of moral and financial prosperity in every community.

Every physician should at once join the thrift movement. It is organized by the Federal Government through the twelve Federal Reserve Districts and is represented in every community by a Savings Director, whose duties are to educate his community as to the advantages and opportunities of thrift and to forward the sale of Thrift Stamps and War Savings Stamps which the Government has made available for reducing the thrift campaign to concrete accomplishment.

———BUY W. S. S.———

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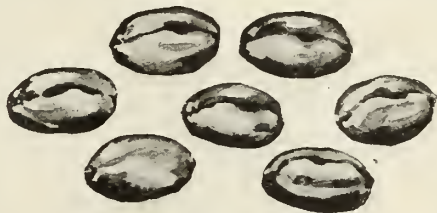
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 Blossom, F. O., Caribou.
 Bisson, N., Waterville.
 Bradford, L. B., Rockland.
 Bundy, H. C., Lakeview.
 Carr, E. B., Rockland.
 Carter, L. F., Bangor.
 Clarke, R. W., Deer Isle.
 Clarke, W. E., Damariscotta.
 Clough, G. H., Dexter.
 Cox, J. F., Bangor.
 Cummings, G. O., Portland.



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*Dennett, G. C., Unity.	*McDonald, C. D., Portland.
Fogg, C. E., Portland.	McKay, H. G., Bangor.
Fogg, N. A., Freeport.	*Marston, H. E., No. Anson.
Foster, N. J., Camden.	Merritt, F. J., Jay.
Foster, T. A., Portland.	Moulton, W. B., Jr., Portland.
Foster, J. H., Farmington.	Sullivan, P. S., Biddeford.
Fox, J. S., Portland.	*Sullivan, T. J., Portland.
Frisbee, E. B., Bridgton.	Rogers, H. D., Hampden.
Frohock, H. W., Rockland.	Rudman, B. W., Portland.
*Fuller, A. J., Swan's Island.	Smith, L. B., Winterport.
Glason, F. P., Gardiner.	Stevenson, H. W., Saco.
Goodrich, E. E., Waterville.	Sumner, C. L., East Millinockett.
Goodwin, H. M., Lincoln.	Taylor, C. J., Bangor.
Goold, W. E., Livermore Falls.	*Thaxter, L. T., Portland.
Gordon, I. L., Lincoln.	*White, Herndon, Portland.
*Hayward, J. A., Portland.	*Whitney, H. R., Windham.
Hamm, J. C., Belfast.	*Vose, S. N., Madison.
Hoffess, C. E., Damariscotta.	Wiley, W. B., Jr., Bangor.
**Howes, H. M., Topsham.	Williams, D. L., Togus.
Johnson, Linwood, Portland.	Williams, H. L., Auburn.
Kennison, W. H., Madison.	Williams, J. B., Bangor.
Kinney, A. G., Blue Hill.	Winch, A. W., Portland.
Knapp, Frank, East Livermore.	Wright, C. S., Portland.
*Kupelian, N. S., Portland.	Wyman, T. C., Portland.
Langwell, M. H., Lewiston.	Young, W. J., Orono.
Leader, R. T., Lewiston.	
Lester, W. H., Auburn.	

*Discharged **Died

*This list is as complete as we are able to obtain. It is impossible to publish the complete membership, owing to the counties not sending in the annual reports.

Correspondence.

MEDICAL REGISTRATION.


DR. JAMES A. SPALDING,
62½ Congress St.,
Portland, Maine.

Dear Doctor: I would like to make some comments on the letter addressed to Dr. Coombs and printed under the heading, "Correspondence," in the May Number of our MEDICAL JOURNAL.

In the first place, it is not considered necessary that a doctor, to be a member of a state medical board, should be an expert in his particular subject. Many of the applicants for examination are men who have been out of medical college a number of years, and practical

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questions are more appropriate than are questions on laboratory and experimental work.

An M. D. professor of physiology or chemistry is considered to be a better teacher in a medical college than a layman, who, outside of his subject, knows nothing about the human body or its diseases. The teaching of physiology in an academic college is vastly inferior to the same course in a good medical college.

Medical men believe that they should control their own profession. If laymen are placed on the Board of Medical Examiners the doctors certainly will not regulate their profession very long.

The medical laws of Maine and most other States specify that a member of the State Medical Board shall not be a member of the faculty of any medical college, and rightly so, and most laws state that a man should have been in active practice in the State for at least five years to be eligible to the Board. The reason for this is very obvious; otherwise, a man could come to the State and under the law suggested might not even be an M. D., and receive an appointment on the Board.

The politicians of the State of Illinois seem to be trying to rival New York State in their zest for making laws to license the so-called drugless practitioners, midwives and other quacks. Other States have not seen fit to follow in their footsteps.

The American Medical Association has done great work in classifying medical colleges and in causing many low-grade schools to close, and many State Boards do not recognize the graduate of a Class "C" college, and some do not recognize graduates of a Class "B" school.

and now it is proposed to register most anyone who comes along and says he is a drugless practitioner. I do not believe that the Maine Board recognizes graduates of a Class "C" school.

There has been a big decrease in the number of medical graduates in recent years and it is expected there will continue to be, and even now there is a shortage of doctors in small towns. Certainly the drugless practitioners cannot replace these physicians. It would be a great injustice to the people, and it would be far better to license graduates of a low-grade medical college.

It does seem as though the medical laws of Maine should be changed and made more drastic, and framed so that it will shut out these people from practice, as their treatment is of no benefit to the public, and the public should be considered first; ourselves secondarily. Some States only require a man to have been in practice in the State three years in order to be appointed to the State Medical Board. There is a tendency everywhere for all kinds of medical sects to make strenuous endeavors to legalize their practice. The trouble with the Maine law is that it is not drastic enough. Magnetic healers, chiropractors, and the like are allowed to inflict themselves on the public.

I think a law should be framed containing clauses such as, "Any person shall be regarded as practicing medicine who shall publicly profess to be a physician, surgeon, practitioner, or healer, or shall treat or offer to treat any disease or disorder, mental or physical; or any deformity or injury by any system or method, or effect cures and charge therefor directly or indirectly money or other compensation, or if a person shall prefix the letters, 'M. D.,' 'M. B.,' 'Professor,' 'Dr.,' 'Doctor,' 'Specialist' or 'Healer' to his or her name, professing to treat physical or mental ailments by means of drugs or by any other method." (Not applying to osteopaths legally registered.)

Socialists and so-called uplifters and reformers are trying to force their views on the people and claiming that health insurance should be at once established in this country. The American Association for Labor Legislation, the society that is pushing such schemes, numbers college professors among its members; in fact, the President of the Association is a professor in one of our largest universities.

Under such a law as proposed, members of the society could easily be placed on the Board, and the consequences of such an action would be far reaching and might prove disastrous to the doctors.

I have thought for some time that we should have a new medical law and that it should be more specific. I hope the society will insist on having a Board made up wholly of doctors who have been in practice in the State for at least three years, and if any change in the law is made that it will be made more drastic and protect the people of our State from these quacks who are trying to get recognition, as we know that their treatment is no good and that they positively do harm, as they will not be able to recognize the serious condition of a patient, and keep treating him until his condition is such that no regular physician can do him any good.

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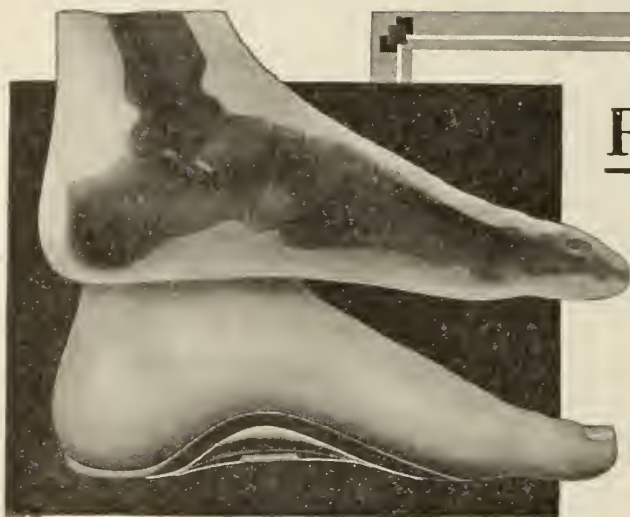
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p 347-70
Maine Medical Association meets at Augusta, June, 1920
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THE JOURNAL

OF



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VOL. IX, No. 12

JULY, 1919.

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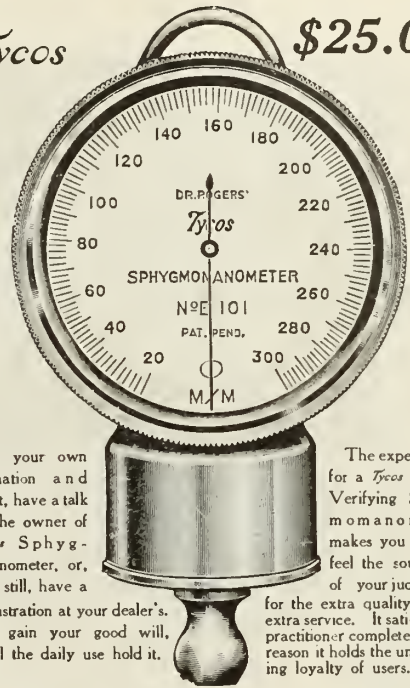
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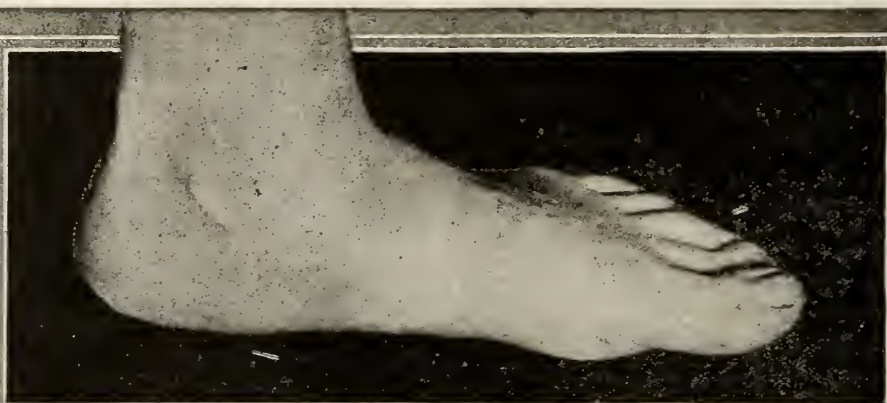
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What fundamental ideas did the house come to represent? One of them was research work!

Long before it could well afford to do so, the company spent thousands upon thousands of dollars in original investigation. In the early days, for example, when the vegetable *materia medica* played a larger role than it does now, we were instrumental in placing many new plant drugs at the disposal of the physician. Twenty-one of these drugs subsequently became official in the National Formulary and the United States Pharmacopœia.

Later on, in the orderly evolution of the *materia medica*, original work was undertaken in the realm of chemical and bio-chemical investigation, and this resulted in the discovery of a considerable number of medicinal agents that proved of distinct value to the physician. Of many such prod-

ucts we need mention only Adrenalin, Pituitrin and Apophesine to suggest the importance of these introductions.

During the last twenty-five years our researches have been especially devoted to subjects in the field of biological and glandular therapy. As early as 1894, indeed, we established a laboratory for the production of antitoxic serums, and since that time we have developed a research staff unequaled by any other commercial organization, and unsurpassed, perhaps, by any agency in the realm of medical investigation.

It is not our purpose to enumerate the new vegetable, chemical, biological and glandular products that we have introduced to the medical profession from time to time. Our object is merely to indicate the part we have played in the development of the *materia medica* during the last fifty-two years.

From the very first we have dedicated ourselves to original investigation. And not always has it been the object of our research work to turn out marketable products. We have frequently spent large sums in exhaustive investigations which in all probability would never lead to any commercial advantage, but which were undertaken with the primary desire to be of service to the medical profession and to humanity.

PARKE, DAVIS & COMPANY

THE JOURNAL

OF THE

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VOL. IX.

JULY, 1919.

NO. 12

PROCEEDINGS AT THE SIXTY-SIXTH ANNUAL MEETING OF THE MAINE MEDICAL ASSOCIATION.

Portland, Maine, June 17-18-19, 1919.

FIRST MEETING OF HOUSE OF DELEGATES,

HELD AT THE COLUMBIA HOTEL, JUNE 17, 1919. AT 8 P. M.

The meeting was called to order by the President, Dr. George Coombs, of Waldoboro.

PRESIDENT COOMBS: Gentlemen, the first business is the reading of the minutes of the last session.

On motion by Dr. Gehring, the reading of the minutes of the last session was dispensed with.

THE PRESIDENT: The first matter to occupy our attention this evening is the report of the Committee on Medical Defense, and Dr. Spalding will make that report.

REPORT OF COMMITTEE ON MEDICAL DEFENSE

Your committee regret that they have accomplished practically nothing since the last meeting, because so many physicians from other States interested in this topic have been abroad. Perusal of many suits for malpractice has, however, again brought out the fact that the courts uphold the lawyer for the plaintiff in asking the defending physician if he is insured, thus giving an opening for the jury to bring in a verdict against him and the insuring corporation. In other

words, many physicians suffer loss of reputation simply because they are insured, whereas, if they were represented by a body of men like our Association, the results would be different, as shown in Massachusetts and other States during the past year. In one State thirteen suits were driven out of court.

We call attention to a curious suit against a physician, with damages set at \$16,000, simply because the patient suffered terrible pain for years and finally died as the result of the injection of a bland aseptic lotion into the bladder, no operation whatsoever being performed. In a second instance a man with a cinder in an eye asked a fellow workman to remove it. This he failed to do, and a surgeon with proper aseptic precautions removed it. The eye, already infected by the comrade's dirty knife, was ruined. The jury gave a verdict against the physician of \$6,000.

We believe that this Association should co-operate with the insuring corporations, that there should be always at hand a committee of conference for every threatened malpractice suit, that any physician found to be the leader in causing the suit to be brought should be shown the error and folly of his situation and intentions, and that a penalty of warning to such offending member would prevent many suits being carried into court; whilst many might be very favorably settled out of court.

Your committee recommend that the ideal should be continued for another year, with a view to offering in 1920 a formulated plan for active medical defense, as has proved of value in twenty-six States.

For the committee,

JAMES A. SPALDING.

On motion by Dr. Gilbert, it was voted that the report be accepted.

THE PRESIDENT: I understand that this report does not contemplate action until 1920. You have therefore adopted this report, the important part of it being that this committee shall be continued for another year.

It was thereupon voted to continue this committee with the same membership as last year.

THE PRESIDENT: I wish to say that in the matter of the work of the Legislative Committee, I believe that there is something that can be done by every member of this Association prior to 1920.

The next report is that of the Committee on Scientific Work, Dr. Gehring, Dr. Abbott and Dr. A. P. Leighton, Jr.

DR. GEHRING: Mr. President, I have nothing further to report beyond what can be read in the program which has been sent to each member of the Association, or, rather, which ought to have been sent to each member, but has not arrived in every instance.

We considered the matter of the program very carefully this year, and, as you have observed, have made one or two departures from the custom that has prevailed in former years. In the first place, we have this year omitted the banquet. It seemed to us that in previous years the banquet was something which was not particularly enjoyed by the members, but who felt that they must attend because it was on the program, so to speak. We also felt that in going

to one of the hotels we were paying rather an exorbitant price, perhaps, for the same supper which they had served earlier in the evening for less money. Furthermore, after we decided to hold a clinic tomorrow afternoon at the hospital, we realized that in all probability we would not get through there until about six o'clock, and, inasmuch as we are to have an address in the evening, which is the second innovation, we decided to omit the banquet.

In making up the program we had in mind bringing to the attention of the Association three important subjects. First, the question of venereal disease, about which some of us here in Cumberland County do not know very much, especially regarding the law concerning the reporting of venereal disease. We felt that it was very essential that we should understand that at the outset. Secondly, the question of social service, which can be handled by no one better than Dr. Cabot; and, thirdly, the question of the medical examiner service, which will be considered by Dr. Leary, who is one of the medical examiners in Suffolk County. Those three topics we wish to bring to the fore in this program. There are other interesting papers on the program, as you must have noted, but we rather laid special emphasis on those three topics as being the important things to consider this year.

THE PRESIDENT: You have heard the report of the Committee on Scientific Work. What action will you take?

On motion the report was adopted.

THE PRESIDENT: Next in order is the report of the Committee on Public Policy and Legislation, composed of Drs. Robinson, Hardy and Beach. I have no doubt they will be here tomorrow to make a report.

As a member ex-officio of that committee, I will report the bills which have been incurred. The committee expended fifty dollars towards the work of a secretary at the State House in keeping track of legislation. Also \$26.06, which had to do with the printing of a circular letter and mailing it. This was very kindly undertaken by the Androscoggin County Medical Society and sanctioned by the Committee on Legislation, urging action on the Workmen's Compensation Act. Also a bill of my own for telephoning, \$59.60, when the osteopath bill got away from the committee, and was stopped at the second reading in the House and the first reading in the Senate, and was about to go through under rather alarming conditions. By telephoning to the secretaries and presidents of the county societies, I believe that the members of the Legislature were quite extensively flooded with letters from doctors and their friends urging that the bill be changed.

It may interest you to know that the original bill, Bill No. 66, was advertised for a hearing before the Judiciary Committee, and that in the midst of that hearing the osteopaths announced that they were to introduce a new bill. The Judiciary Committee virtually promised that we should have full notice of the bill and its features, and, if necessary, a hearing; but the first notice we had of it was that a new bill had been reported favorably to the House and Senate and was well on its way to passage. As I say, by dint of telephoning, the thing was stopped, and the objectionable features, as we saw them, were taken out from that section which had to do with declaring that the practice of osteopathy was

not the practice of medicine. The osteopathic registration bill was finally passed, and seemed to be the best that could be done under the circumstances. There is no question that, by the next session of the Legislature—though possibly not until the session after—the chiropractors will also want to be recognized, and very likely several of the other sects. I believe that this Association should urge upon all of its members to keep very much awake in the matter of medical legislation, and the time to begin the work with the Legislative Committee is now. The work of this committee cannot be done by the committee alone. Every member of this Association is personally responsible for the results of that work. If you know of anything with reference to the laws which affects our practice, it seems to me that it is your duty to inform the Legislative Committee of it at the time it comes to your attention, so that committee will be ready to take vigorous action, and perhaps be able to place before the Association at its next meeting a plan whereby this committee, or this Association, may take aggressive action in getting that type of legislation through which we know belongs to us. The committee cannot do this work alone.

Dr. Robinson's expenses were \$10.00; my expenses, traveling expenses, to Augusta three times and to Waterville to meet the committee once (all those times I was obliged to stop over night), \$25.00. Dr. Beach's expenses were \$7.30, and to Mr. Pattangall was paid a fee of \$85.00 for legal services, making a total of \$263.84.

You all read in a recent number of the JOURNAL a letter from Dr. Beach with reference to medical legislation, and when that comes up in Dr. Beach's report, I wish to make known to you some letters I have received upon the subject.

THE PRESIDENT: The next report is that of the Committee on Venereal Diseases, and we will listen to the chairman of that committee, Dr. Whittier.

REPORT OF THE COMMITTEE ON VENEREAL DISEASES AND THEIR PREVENTION.

DR. WHITTIER: Mr. President and Members of the House of Delegates:

The Committee on Venereal Diseases and Their Prevention was appointed June 28th, 1910, at the annual meeting at Bar Harbor. It was understood that the work of the committee was to be twofold.

1. To make investigations relative to effects and frequency of these diseases, especially with reference to Maine.
2. To do whatever might be possible in the way of prevention of venereal diseases in Maine.

In the first year Maine worked along these lines:

1. Collection of statistics regarding the frequency and disastrous effects of these diseases.
2. Investigation of what had been done along the lines of prevention abroad and in this country.
3. Consideration of various plans for the prevention of venereal diseases.

At the meeting of the Association in 1911 the committee reported as follows:

As a result of a study of statistics your committee is convinced that there is good reason for believing

1. That venereal disease destroys more lives than tuberculosis.
2. That venereal disease is more prevalent than all other contagious diseases combined.
3. That taking into consideration the sterility, the wrecked homes and the ruined lives caused by venereal disease it is one of the worst evils in the world to-day.

The committee believed that education and striving for a higher ideal of sex morality were the two lines that promised most. The committee recommended that the State Board of Health undertake the campaign of education, and that syphilis, chancroid and gonorrhea be added to the list of diseases required to be reported to the State Board of Health by number, not by name. The committee advised a plan of co-operation with the State Board. This first report of the committee was approved and the committee continued. The report of the committee and the action of the Association were immediately brought to the attention of the State Board of Health. The officers of the State Board expressed themselves as being in sympathy with the plans of the committee, but on account of the lack of funds could not co-operate actively.

At a special joint meeting of the committee with the Board in 1912, resolutions were passed by the Board approving the dissemination of knowledge concerning the dangers of venereal infection and stating as the sentiment of the Board that syphilis, gonorrhea and chancroid should properly be included in the list of infective diseases made reportable by law, provided such diseases be reported by number and not by name. On account of the inability of the Board of Health to finance the proposed campaign, it was necessary for the committee to raise funds. This work was at once begun, and altogether over three thousand dollars has been raised besides the funds given by the Association.

The committee decided that the following lines promised most in the way of results for Maine:

1. Assisting in awakening the people of Maine to the dangers of venereal disease.
2. Assisting in some degree in establishing higher ideals of sexual morality.
3. Arousing parents to a sense of responsibility in regard to the sexual morals of their children.
4. Calling the attention of parents to the need of developing in their children a feeling of responsibility in regard to the health and welfare of their future families.
5. Assisting in awakening public opinion to support officers of sanitation in applying modern methods to the control of venereal disease.

During the two years of war time your committee has been obliged to curtail its work greatly. Two of the three members have been in service, and for that reason and because of the many drives and solicitations for other purposes no contributions have been solicited. During the two years the expenditures have amounted to \$185.69. During the same the receipts have amounted to \$271.61. The balance on hand two years ago was \$342.13. This year the balance on hand is \$428.05. The following personal contributions have been received:

Dr. James A. Spalding, Portland,	\$ 2.00
Mr. C. H. Payson, Portland,	25.00
Mrs. Maria W. Prentiss, Bangor,	15.00
Professor F. E. Woodruff, Bowdoin College,	2.00
Mrs. John Storer Cobb, Cambridge, Mass.,	20.00
Total,	<hr/> \$64.00

It is now the plan of your committee to take up actively the work that was given up two years ago and to pay special attention to arousing parents to a sense of responsibility in regard to the sexual morals of their children and developing in young people the sense of responsibility for the health of future families. It has been a source of great satisfaction to your committee to see so much of the work taken up and carried on by various organizations and by State and National Governments. Perhaps the greatest advance during the year has been the passage of the Chamberlain-Kuhn Act, of which the following is a summary:

"AN ACT to Protect the Military and Naval Forces of the United States against Venereal Diseases, and for other purposes.

"SECTION 1. Creates an 'Interdepartmental Social Hygiene Board' to consist of the Secretary of War, Secretary of the Navy and the Secretary of the Treasury as ex-officio members, and of the Surgeon General of the Army, the Surgeon General of the Navy, and the Surgeon General of the Public Health Service, or of persons whom the Secretary of the Army, Navy and Treasury may respectively designate. The duties of the board shall be (1) to recommend rules and regulations for the expenditures of moneys allotted the States under section two; (2) to select the institutions and fix the allotments to each institution under sections three and four; and (3) to recommend to the Secretaries of the War, Navy and Treasury such general measures as will promote correlation and efficiency in carrying out the purposes of this act.

"SEC. 2. Authorizes and directs the Secretary of War and the Secretary of the Navy to adopt measures 'for the purpose of assisting the various states in caring for civilian persons whose detention, isolation, quarantine or commitment to institutions may be found necessary for the protection of the military and naval forces of the United States against venereal disease.'

"SEC. 3. Establishes a Division of Venereal Diseases in the Bureau of the Public Health Service.

"SEC. 4. Specifies the duties of the Division of Venereal Diseases.

"SEC. 5. Appropriates \$4,000,000 to carry out the provisions of sections 1, 2, 3, and 4 of this act.

"SEC. 6. Provides that the term 'states' and 'state' used in this act include the District of Columbia."

This Act was before Congress at the time of the meeting of our Association last June. A synopsis of the bill was read before the Association and the following resolution was adopted:

"The Maine Medical Association, in session at Portland, June 6, 1918, hereby indorses proposed bill, Senate Bill 4608 and House Bill 12258, for the protection of the military and naval forces of the United States against venereal disease and directs that a copy of this resolution be sent to the Maine Senators and Representatives at Washington."

The chairman of your committee sent copies of the resolution to all the Maine Senators and Representatives. All promised to support the bill and your resolution was introduced into the Senate by Senator Hale. The bill passed both Houses of Congress July 6, 1918. It has already been productive of much benefit to the cause of social purity among the military and naval forces of the United States and among the civilian population as well. I presume that Dr. Hitchcock will speak tomorrow of the work accomplished in Maine under this act.

During the last session of the Legislature a bill was introduced covering the same ground as the Red Light Abatement Act of Oregon and California. Your committee supported this bill, but it failed to pass. The Legislature, however, did pass a somewhat similar bill approved by the Social Hygiene Board established under the Chamberlain-Kuhn Act. Following is a copy of the act as passed:

CHAPTER 112.

"AN ACT Defining Prostitution, Lewdness and Assignment and Providing Punishments Therefor.

"Whereas, owing to the necessity of preserving the public health in general, the enactment of more stringent laws prohibiting prostitution, lewdness and assignment, and providing punishments therefor is an emergency measure immediately necessary for the preservation of the public peace, health or safety, now, therefore,

"Be it enacted, etc.:

"SECTION 1. That from and after the passage of this act it shall be unlawful:

"(a) To occupy any place, structure, building or conveyance for the purpose of prostitution, lewdness or assignment or for any person to permit any place, structure, building or conveyance owned by him or under his control to be used for the purpose of prostitution, lewdness or assignment with knowledge or reasonable cause to know that the same is, or is to be, used for such purpose;

"(b) To receive or to offer or agree to receive any person into any place, structure, building or conveyance for the purpose of prostitution, lewdness or assignment, or to permit any person to remain there for such purpose;

"(c) To direct, take or transport or to offer or agree to take or transport, any person to any place, structure or building, or to any other person with knowledge or reasonable cause to know that the purposes of such directing, taking or transporting is prostitution, lewdness or assignment;

"(d) To procure or solicit or to offer to procure or solicit, for the purpose of prostitution, lewdness or assignment;

"(e) To reside in, enter or remain in any place, structure or building, or to enter or remain in any conveyance for the purpose of prostitution, lewdness or assignment;

"(f) To engage in prostitution, lewdness or assignment or to aid or abet prostitution, lewdness or assignment by any means whatsoever.

"SEC. 2. That the term 'prostitution' shall be construed to include the offering or receiving of the body for sexual intercourse for hire, and, shall also be construed to include the offering or receiving of the body for indiscriminate sexual intercourse without hire. That the term 'lewdness' shall be construed to include any indecent or obscene act. That the term 'assignment' shall be construed to

include the making of any appointment or engagement for prostitution or lewdness or any act in furtherance of such appointment or engagement.

"SEC. 3. That in the trial of any person charged with a violation of any of the provisions of section one of this act, the record of a prior conviction or testimony concerning the reputation, of any place, structure or building, and of the person or persons who reside in or frequent the same shall be admissible in evidence in support of the charge.

"SEC. 4. (a) That any person who violates any of the provisions of this act shall be subject to imprisonment in, or commitment to, any penal or reformatory institution in this state for not more than three years;

"(b) That probation or parole shall be granted or ordered in the case of a person infected with venereal disease only on such terms and conditions as shall insure medical treatment therefor and prevent the spread thereof, and the court may order any convicted defendant to be examined for venereal disease.

"(c) That no girl or woman who shall be convicted under this act shall be placed on probation or on parole in the care or charge of any person except a woman probation officer.

"SEC. 5. That the declaration by the courts of any of the provisions of this act as being in violation of the constitution of this state shall not invalidate the remaining provisions.

"SEC. 6. All acts or parts of acts inconsistent herewith are hereby repealed.

"SEC. 7. In view of the emergency cited in the preamble this act shall take effect when approved."

[Approved, March 27, 1919.]

The following are extracts from some of the letters received endorsing legislation relative to venereal disease:

Honorable Frederick Hale, Washington, D. C.:

"I have your letter of June 10th embodying resolution passed at the annual session of the Maine Medical Association at Portland, June 8th, endorsing Senate Bill 4608 and 12258.

"I am introducing the resolution in the Senate at your request."

H. H. Moore, Chairman, Emergency Committee for Social Hygiene:

"Those were capital letters you sent us from the Maine members of Congress. We greatly appreciate your co-operation.

"We are also glad to have a copy of the resolution which was adopted by the Maine Medical Association and to know that this resolution has been sent to the Maine Senators and Representatives.

"You will be interested to know that the bill is making good progress. The first hearing before the Senate Committee was held to-day."

Hon. Julius Kahn, House of Representatives, Washington:

"I have your letter of June 27th endorsing the bill I have introduced in the House of Representatives for the eradication of venereal disease in the Army and Navy. I am glad to know of the interest of the Maine Medical Association in this matter and assure you that I will do my utmost to have the measure enacted into law."

[June 29, 1918.]

H. H. Howe, Chairman, Emergency Committee for Social Hygiene:

"I am glad to tell you that the bill 'To protect the military and naval forces

of the United States against venereal disease and for other purposes' was passed by both Houses of the Congress on July 6th, as an amendment to the general Army Appropriations bill.

"With appreciation of your fine co-operation, I am."

[July 8, 1918.]

Hon. Howard Davies, Augusta, Maine:

"I regret exceedingly that the Legislature did not act favorably upon the bill which you caused to be presented, having for its object the suppression of vice and lewdness.

"You are doing a wonderful work, and your painstaking campaign for the regulation and prevention of venereal diseases must be bearing splendid results."

[April 7, 1919.]

Following is the financial report for the year ending June, 1919:

RECEIPTS.	
Contribution 1918-19,	\$62.00
Maine Medical Association,	23.00
Interest, Prince A. Morrow Memorial Fund,	72.00
Interest, Savings Bank Deposit,	5.67
	<hr/>
Balance on hand June, 1918,	278.38
	<hr/>
Total,	\$443.05
EXPENDITURES.	
Stamps,	\$ 2.00
Clerical work,	13.00
	<hr/>
	\$15.00
	<hr/>
Balance on hand in the Brunswick Savings Institution, June, 1919,	\$428.05

Your committee has on hand a considerable number of pamphlets written by Dr. Belfield, also several hundred pamphlets of the American Medical Association. These pamphlets are well adapted for the work of your committee among parents and children of grammar school age. The booklets and circulars used by the Social Hygiene Board are not in the opinion of your committee so well adapted for its work.

RECOMMENDATIONS.

Your committee feels that the need for work along the lines previously laid down is by no means lessened under the present conditions. It therefore asks that the committee be continued and that the Association make the usual appropriation of \$25.00 that has been granted annually for the past few years.

Respectfully submitted,

F. N. WHITTIER,
A. L. STANWOOD,
R. H. HOLLAND.

Dr. Whittier then said as follows:

In view of the great amount of work that has been undertaken relative to public health service by the government organizations, the need of the work of this committee is lessened, but it seems to me that the committee can cover a ground that is not covered by the organizations now working. Especially this

field of appealing to parents and to the younger children is a field which is not covered by other organizations very thoroughly at the present time. It is the belief of the committee that this is a time in the world's history when work of this sort is especially necessary, and that a line of appeal should be adopted in certain cases different from the appeal that is ordinarily made. There is a limit to the appeal that one can make by representing the dangers of venereal disease. We all know that under certain conditions the dangers set forth do not have very much effect on people to whom they are shown—the boys especially. They love danger, and no matter how forcibly you may represent these dangers you will still have license and venereal disease. Then, too, the prophylactic measures that have been adopted and taught to all the four million soldiers in the army are easy of application, and they have held out a certain measure of safety to the individual using them, affording a hope and a promise, largely delusive, I believe, that a man may be able to indulge in illicit sexual intercourse and escape the consequences. Then, too, the natural trend of life in many quarters in these days is perhaps toward license—toward an easier morality than existed in the old days. I do not know that you will agree with me, but it seems as though we must have a different idea of morality, a different idea of religion, to preach to the young now than was preached a generation ago. The older men here remember in their youth the strict orthodox belief. They had a real heaven then to preach to the young, and a hell that was no less real. These are not preached any more and you must appeal to the young people in a different way, and this different way your committee believes is by preaching a higher ideal of sexual morality, and representing to parents, and to children as soon as they are old enough to understand the line of reasoning, the necessity of keeping clean and pure, and passing down good, healthy morals and good, sound bodies to their children. I thank you. (Applause.)

On motion it was voted to accept the report and the recommendations therein contained.

THE PRESIDENT: The next in order is the report of the Committee on Necrology, which Dr. Spalding will make tomorrow.

Next is the report of the delegate to the American Medical Association, Dr. Gilbert.

REPORT OF THE DELEGATE TO THE A. M. A.

The seventieth annual session of the A. M. A. was aptly called the "victory meeting." At the election of officers the speaker of the present House of Delegates was nominated as President-elect in a very flowery speech and was qualified in every way to fulfill this high office, but when the delegate representing the Navy rose, and, briefly reviewing the work of the world war, nominated Admiral Barnstead as President-elect, the applause was loud and long, while many rose to second the nomination. To cap it all, Speaker Worth withdrew his name and seconded the Barnstead nomination amid a round of applause. The election was unanimous.

It was a session largely devoted to the work done by the Association and its members during the war. It not only dominated the general assemblies, but played a generous part in the meetings of the sections in the form of papers and the discussions.

It is impossible to review the great amount of work done the past year by the A. M. A., as time will not permit; however, I will briefly touch on a few of the activities which should interest us all.

This great organization, with a membership of 82,288 and a fellowship of 45,412, was of considerable assistance to the War Department in many ways during the period of organization of the Medical Corps of the Army and Navy.

Some of its activities are embodied in the Journal of the A. M. A., Archives of Internal Medicine, American Journal of the Diseases of Children, Archives of Neurology and Psychiatry, A. M. A. Directory, Quarterly Cumulative Medical Index, Reports on Pharmacy and Chemistry, Propaganda Department, Manual of Treatment of Venereal Disease, and conducts the Co-operative Advertising Bureau for the benefit of the State medical journals.

The report of the Council of Health and Public Instruction is well worth reading, dealing with Health Problems, Vital Statistics, Legislature and Social Insurance under the chairmanship of Victor C. Vaughn.

The report of the Council of Medical Education is exhaustive, dealing with Educational Standards; Preliminary Education, Inspection and Classification of Medical Schools, Improving Medical Education, Graduate Medical Instruction and all phases of hospital work, such as Standardization, Records, Equipment, Training of Internes, etc., and finally the needs of the country for physicians.

This brief résumé can give you only a slight idea of what the Association is doing, an organization with assets over half a million dollars, whose business affairs are conducted in the same manner as your State Association.

It is true that petty politics play more or less in the election of officers, but where the work of the Association is concerned, three years in the national House has convinced me that politics play no part in the actual business conduct of the Association. The national House is made up by representatives from the States in ratio of 1 to 700 membership in the State Associations. The true value of State representation in the national House does not lie in numbers but in a thorough knowledge of the conduct of business by the House, so that if Maine ever wishes to take an active part in the national affairs, it should send as a delegate a member who is familiar with the needs of his own Association and has sufficient interest in organization work to study the national House and become an active member therein. Nearly all States have recognized the importance of this and have made the Secretary the delegate, with expenses paid. Such a plan not only assures Maine's representation in the national body, but such a delegate would bring back to his Association not only a knowledge of the business conducted by the House affecting the State societies, but a knowledge of how other societies were meeting problems common to all States.

FRANK Y. GILBERT,

Delegate A. M. A.

On motion it was voted to accept the report.

THE PRESIDENT: From two years' daily association in the same hospital as an interne with the President of the American Medical Association, I want to assure you that that Association has a President-elect who is certainly worthy of the office which has been given to him.

There have been during the past year a great many suggestions that, instead of electing a delegate to the American Medical Association

tion for one year, and that delegate the retiring President, that a delegate be elected at least in accordance with the constitution of the parent association—for two years—and that in order that this work may be thoroughly done, and that interest may be taken in it outside of personal elements, it has been suggested by many, as Dr. Gilbert has said in his report that the expenses of that delegate be paid by this Association. It seems to me that these two points should be taken up by the full meeting of the Association. It is a change from what has been going on for several years. Personally, I would be very glad to part with any so-called sentimental ideas as to being a delegate to the American Medical Association. I believe it is time that the Maine Medical Association had a representative in the parent House of Delegates whose presence will be felt there, and to that end I make the suggestion that this matter be brought up at the full meeting of the Association. Dr. Bryant suggests that right now would be a good time for the House of Delegates to discuss this question, and I would be very glad to hear from other members.

DR. GEHRING: Does that require a revision of the constitution and by-laws?

DR. BRYANT: No.

THE PRESIDENT: The by-laws state practically that a delegate shall be elected by the House of Delegates, and that delegate is nominated by the Nominating Committee in accordance with the constitution of the A. M. A.

DR. BRYANT: The constitution of the A. M. A. says the delegates shall be elected for two years, but there is nothing touching upon it in our constitution whatever, except that the delegates shall be elected.

DR. GEHRING: It has been customary, then, to appoint the retiring President?

DR. BRYANT: A matter of custom.

THE PRESIDENT: Last year the retiring President could not serve as a delegate because he did not happen to be a fellow of the American Medical Association, and therefore the Council, by mailed ballot, elected Dr. Gilbert, Dr. Bryant being unable to attend. I wish that there might be expressions in relation to this from other members here, so that the report that goes out to the society in our transactions might cover definite expressions in relation to it.

DR. GEHRING: Mr. President, I will say for one that it seems to me that Dr. Gilbert's recommendations are excellent in this matter.

Those of us who have had any experience at all in bodies of one kind and another know that the man who has had some experience is the man who gets the most out of it. In other words, if we send a man to the House of Delegates of the American Medical Association who does not know the ropes at all, he is not going to get very much out of it to bring back to us. For that reason it would seem to me that since he is going there as our representative, we ought to have a man who is familiar with the workings of the larger body in order that he may know where to get things, how to get them, and, knowing our own condition here in Maine, how he may get those very things which we most need. On the other hand, if one individual has to do that from year to year, it would seem only just that his expenses should be paid. I am very heartily in favor of this.

THE PRESIDENT: Gentlemen, I think, to bring this definitely before the House of Delegates, I will ask for a motion on the point.

DR. GILBERT: Mr. President, I will make the motion that it is the sentiment of this House that the delegates shall be elected for a period of two years and his expenses paid, and recommend his re-election at the expiration of this term. It is my experience that a man ought to continue there year after year.

THE PRESIDENT: I will say that in my address I intended making that particular point that he be elected for two years, and that it be permissible to continue his services. Your motion is that the delegate shall be elected for two years, and shall be subject to re-election?

DR. GILBERT: That it is the sentiment of the House that he shall be subject to re-election, and his expenses paid.

Dr. Gilbert's motion was then unanimously passed.

THE PRESIDENT: Dr. Gilbert made a suggestion in his report that the Secretary of the Association be that delegate. Does Dr. Gilbert wish to make that as an additional motion or leave it to the House of Delegates?

DR. GILBERT: It is very desirable, owing to his knowledge of State affairs, but I imagine, Mr. President, that it had better be left for the Nominating Committee to decide.

THE PRESIDENT: Visitors to State Sanatoriums—Dr. Welch, Dr. Spear and Dr. Bunker. Has Dr. Spear a report to make?

DR. SPEAR: I do not think I have any report to make, Mr. President. I have never received any notice, and only knew I was on this committee by reading it in the JOURNAL one day.

THE PRESIDENT: Next in order is the report of the Managing Editor of the JOURNAL of the Association, Dr. Gilbert.

REPORT OF THE MANAGING EDITOR.

Your JOURNAL has just passed through one of the most trying periods known to history, and shown its stability in continuing without interruption its twelve issues, containing all matter presented at your last session, together with other material from the medical societies.

During the war, there was not only the increased cost of labor, resulting in vast increased cost of materials, but the government placed certain restrictions on the amount of paper, the kind, etc., which added to the difficulties of our work. In addition to this, your managing editor was in the service six months, but was fortunately situated at Camp Devens, and by returning at intervals he was able to keep in touch with the affairs of the JOURNAL.

It seems quite superfluous to speak again of the activities of our ex-President, Dr Spalding, but knowing his work as no other can, I should be very remiss if I did not again call to the attention of the Association his enthusiasm and untiring work in behalf of your JOURNAL.

It must be borne in mind that the literary part of a medical publication must depend largely on the support it receives from the Association members by way of contributions. It is impossible to send men over the State for items of interest, owing to the expense, but if the members would only send to your nearest editor any personal items, interesting papers, case reports and reports of medical meetings, it would greatly assist in carrying on this work. As the official organ of the State Association, it should place before the members all matters of interest to them. It is not in the field of competition in medical-journalism but aims to keep the members scattered over the State in touch with each other, and we will welcome any suggestions towards accomplishing this end.

Up to five years ago, there were twenty State medical journals, and the editors met each year during the session of the A. M. A. to discuss various phases of the work. At the Minneapolis session, some five years ago, we urged the need of some advertising bureau to secure advertisements for all the State journals and pass on their financial status and their products, as the State journals agreed to close their advertising pages to all products not accepted by the Council on Pharmacy and Chemistry of the A. M. A. There are now twenty-six State journals, representing thirty-one States, whose advertising is cared for by the Co-operative Advertising Bureau, which was started by the A. M. A. and is now financed by the business it secures. These twenty-six State journals, together with the *Journal of the A. M. A.*, represent the highest type of medical journalism in this country, and their influence for good to the profession and the public is constantly in evidence.

The cost to the Association has been about \$500.00 a year during this time, which is less than the cost of printing and mailing the transactions ten years ago, when the membership was about 400, and the cost of printing, paper, etc., was considerably less.

Your JOURNAL has proved its stability through a very trying period, and there can be no question as to its continuance at considerable less cost to the Association than any other form of publication. However, it needs the co-operation of the members in two ways: First, contributions in the form of papers, case reports, personalities, reports of medical meetings, etc.; Secondly,

Your patronage to the concerns advertising in the JOURNAL. Just bear in mind that no advertisement is accepted from any concern whose products have not been submitted to the Council on Pharmacy and Chemistry and accepted on the grounds that they are just what they are represented to be and no false claims made concerning their curative value. They well deserve your support.

During the war, every effort was made to keep our honor roll straight, and our mailing list has been confused from men closing their office and leaving no address when they entered the service. It will require some few months to straighten these out, and we will welcome any assistance from members.

FRANK Y. GILBERT,
Managing Editor.

On motion it was voted to accept the report.

THE PRESIDENT: It is customary to nominate a Budget Committee, and that committee is usually the Board of Councilors and the Treasurer.

Thereupon it was voted that the Board of Councilors and the Treasurer act as Budget Committee.

THE PRESIDENT: I will name as the Committee on Nominations for all offices (including membership of the committees) except the President, Dr. Spear, Dr. Garcelon, Dr. Smith, Dr. Gehring and Dr. Mason.

I wish to bring before you a letter which I have received from Dr. Rowe, of Augusta, which I will read:

DR. GEORGE COOMBS,
President Maine Medical Association,
Waldoboro, Maine.

Dear Doctor: I am enclosing a copy of the fee list adopted by the New Hampshire Medical Society at the annual meeting May 16, 1918, and copied from the transactions for that year.

I am a member of the New Hampshire Medical Society, but did not attend that meeting. Some of the doctors stated that when they put up the fees the people complained and accused some of them of forming a medical trust, and it was thought that if the State society adopted a general schedule it would not be criticized, and the men would have some general plan to follow.

I do not know whether our Maine Medical Society has ever adopted a general schedule or not. Several of our members who have seen this schedule of fees think that it would be a good thing for the Maine society to adopt one similar. Conditions are much the same in New Hampshire and Maine.

I hope the society will take a vote protesting the raising of the narcotic registration fee from one to three dollars. It is very unjust to the medical men, as they are not benefited in any way by the law but are caused a great deal of trouble by it.

An official copy of the enclosed fee list could be obtained of Dr. D. E. Sullivan, Secretary, Concord, New Hampshire.

I do not know whether it was altered in any way at the annual meeting held this month or not. I do not believe I will be able to attend the annual meeting.

Sincerely yours,

FRANK E. ROWE, M. D.

THE PRESIDENT: I have a copy of this fee list, and will refer the matter to a committee of the House of Delegates consisting of Dr. Miner, of Calais, Dr. Garcelon, of Lewiston, and Dr. Charles Leighton, of Portland, for them to report at a subsequent meeting of the House of Delegates.

Dr. Rowe wrote me this suggestion: "I hope the society will take a vote protesting the raising of the narcotic registration fee from one to three dollars." I will say that the report of the American Medical Association shows that that thing was taken up by them. Did you hear that, Dr. Gilbert, in the House of Delegates?

DR. GILBERT: I was not present at that particular meeting, but I saw that it had been taken up.

THE PRESIDENT: Has anyone here a suggestion or motion to make on that particular subject?

DR. GARCELON: Was that taken up by county societies generally?

THE PRESIDENT: No.

DR. GARCELON: I will say that in Androscoggin County we took up the matter, and the action taken was that we should notify our Senators-elect and Representatives regarding our position on that narcotic fee as being against it on the ground that it was simply a public health measure and that they had turned it into a revenue measure; and it was voted to act in co-operation with druggists, dentists and others who were affected by that law.

THE PRESIDENT: Is there anything further? A motion is in order.

On motion by Dr. Williams, it was voted, that a committee of three be appointed by the Chair to take action on this matter and report to the House of Delegates later.

The Chair thereupon appointed as such committee Dr. Williams, Dr. Turner, of Augusta, and Dr. Call, of Lewiston.

THE PRESIDENT: Dr. Spalding asked me to bring this subject before the House of Delegates: Considering that nearly one-half the recruits from Maine in the recent war were unable to fight for the Nation owing to physical deformities which might have been discovered and largely relieved in childhood, the Maine Medical Association in session urges Gov. Milliken to incorporate in his call for any extra

session of the Legislature the imperative necessity of legalizing compulsory physical examination of all school children of Maine in place of the present voluntary system. Dr. Spalding hopes that this Association will pass a resolution, addressed to the Governor, urging him to take that action. We know that this was before the Legislature and dropped, and the question is whether we will pass a resolution to that effect.

DR. WHITTIER: Mr. Chairman, I am not a member of the House of Delegates, but I might say a word on that question with your permission.

THE PRESIDENT: You have permission, Dr. Whittier.

DR. WHITTIER: I feel that such a resolution should have a passage, and I wish very much that the House of Delegates might see its way clear to add to the recommendation that some sort of system of voluntary physical training be adopted by the State of Maine. Many of the States are adopting systems of physical education. New York within the last few years has adopted such a system and has provided for it in a very broad and generous way. Other States have done the same thing and many others are considering doing it. I believe in a system of examination, but a system of examination backed up by a system of physical education would be a much more thorough and better thing. A system of physical education for schools does not entail great expense. Those of you who have been in the service know what a great deal can be done with bodies of people in the way of physical education without any apparatus whatever. The work that was done with the recruits in the army could be done in a modified way with children in the Maine schools, and without entailing any great expense. I, myself, have seen in foreign countries—in Germany, in Sweden, and in England, even—gymnastics for schools carried on on a large scale without apparatus, to the very great benefit of the children who have been given the course. I know that I am not speaking directly to the resolution, Mr. Chairman, but I take advantage of this opportunity of expressing my belief that this move for requiring physical education is coming, and it will be a fine thing if Maine can live up to its State motto and be among the first to adopt such a system.

THE PRESIDENT: I am sure we are very glad to hear Dr. Whittier's expressions on this topic, and what action shall we take?

DR. GILBERT: I would like to say, Mr. President, that Dr. Spalding has been in the office several times about this. I was out of touch

with the legislative work and had only a vague idea of any action taken, but it seems that the matter was sidetracked. I know that Dr. Spalding has given liberally of his time and thought to this one thing, and he has worked hard. My personal feeling is that he should receive the support of the House of Delegates in a measure of this kind.

THE PRESIDENT: Will you put it in the form of a motion?

DR. GILBERT: What action did he ask?

THE PRESIDENT: He asks that the Maine Medical Association shall urge Gov. Milliken to incorporate in his call for an extra session of the Legislature the imperative necessity of legalizing compulsory physical examinations of all school children in Maine in place of the present voluntary system, and Dr. Whittier wishes to add to that, just what, Doctor?

DR. WHITTIER: I should be glad if the House of Delegates could see its way clear to add to it a resolution also endorsing a compulsory system of physical education of the school children of Maine.

DR. GILBERT: I will make that motion, Mr. President.

THE PRESIDENT: You have heard the motion. Is there anything further to be said on the subject?

DR. GARCELON: Mr. President, I am in favor of the motion, but it seems to me that you may meet with opposition from different organizations, such as the Christian Scientists, osteopaths and chiropractors, if you advocate compulsory physical examination. While I am in favor of it, I think that side of the matter should be considered before we pass such a vote. So far as the compulsory physical training goes, I do not think that would meet with any opposition.

THE PRESIDENT: How would it do, Dr. Gilbert, to table the matter and refer it to a committee to draft a resolution?

DR. GILBERT: I think that would be a very good idea, and, as the previous motion was not seconded, I make the motion that it be referred to a committee to be appointed by the Chair, to report later.

The motion being duly seconded was unanimously carried, and the Chair appointed as such committee Dr. Gilbert, Dr. Garcelon and Dr. Green.

THE PRESIDENT: We will now listen to the reports of the Secretary and Treasurer.

DR. BRYANT: Mr. President and Members of the House of Delegates:

All the societies this year have reported in. It has been somewhat difficult to keep things going because various secretaries and members of the county societies have been in the service, and for that reason it has been very difficult to keep in touch with the various associations. In some of the societies, not only the secretaries but the presidents have been in the service. The coming year, after things get straightened out, the work of the Association should be put on a more systematic basis, so that we may get monthly or bi-monthly reports instead of practically one report for the year, and it would be a suggestion of mine that there be one meeting each year of the secretaries of the different component county societies with the Secretary of the State Association for the purpose of mapping out plans for the ensuing year, thus keeping more closely in touch with our different county societies.

MEMBERSHIP.

	1919.	Service.	1918.
Androscoggin reports	60	11	51
Aroostook,	48	7	49
Cumberland,	146	42	146
Franklin,	18	3	19
Hancock,	23	5	21
Kennebec,	70	20	73
Knox,	22	3	22
Oxford,	41	6	36
Penobscot,	87	29	88
Piscataquis,	19	4	20
Sagadahoc,	20	3	17
Somerset,	16	0	18
Waldo,	11	5	11
Washington,	35	2	35
York,	73	7	71
Those paying directly,	10	0	11
Total,	699		

This makes the total membership of the Association 699 members. Of these 149 have been in the service. Last year there were 688 members, so that we have a gain of 11.

It has been practically impossible, with the make-up of our committees, to get much active work done except the absolutely necessary work. This year we should see to it that we put active members on the committees and that they be notified of their appointment. At the same time an outline of their duties should be given them. At the present time there is being made out by the American Medical Association, office of the Secretary, work for these various members, so that this year, after we get settled down, we hope that every committee will have its duties laid out, and that we shall get a report from every committee next year.

REPORT OF THE TREASURER.

June 1, 1918, cash on hand,	\$2,841.34
Received from dues to June 1, 1919,	2,240.00
	<hr/>
	\$5,081.34
Cash paid out of the treasury up to June 1, 1919,	1,092.52
	<hr/>
Leaving balance in treasury June 1, 1919,	\$3,988.82

There are left unpaid bills coming in after June 1st—part of them these legislative bills—of about \$100 or \$125; so that there is in the treasury at the present time something like \$3,800 to be carried over to next year's account, with practically all bills paid.

I would call the attention of the Association at this time to the fact that we have been paying dues of four dollars for the last two years while the men were in service, and it will be a matter for consideration whether we shall continue paying four dollars or drop back to two dollars. In comparison with other State associations, dues of two dollars are very small, and, if you are going to take on additional expenses, you have got to have the money to do business with. So it is up to the House of Delegates now to consider the matter of what the dues shall be for the coming year.

Perhaps it would be well to put in the detailed expenses at this time:

F. N. Whittier, Venereal Disease Committee,	\$25.00
J. A. Spalding, the usual amount of	25.00
H. D. Chadwick, who came down here to give a paper last year,	5.00
Baston Bros., for buttons,	23.00
Marks Printing House, printing programs,	28.00
F. H. Clifford, for printing,	1.65
Bangor Co-operative Co., for printing,	6.00
Marks Printing House, another printing bill,	9.90
Treasurer's bond,	5.00
Cecil Clay, stenographer,	119.42
Paid to the JOURNAL,	500.00
H. W. Shaylor, Jr., for use of lantern,	10.00
Dow & Pinkham, for insurance on the library,	7.10
Georgia A. Fales, Legislative Committee,	50.00
John G. West, Legislative Committee,	26.06
George H. Coombs, telephoning,	59.60
P. H. Burr, for printing constitutions,	60.25
(We had 500 copies of the constitution provided for, but we could find but one copy in existence, and that was in the Secretary's hands.)	
E. W. Gehring, expense getting out program,	16.88
Southworth Bros., printing programs,	23.75
Secretary and Treasurer's salaries,	100.00
Postage,	2.40
Balance in treasury, \$3,988.82.	

All the bills are here with the checks for the Auditing Committee.

THE PRESIDENT: A motion is in order to accept the report of the Secretary.

On motion by Dr. Gehring, it was voted to accept the report of the Secretary, and on further motion by the same gentleman it was voted to refer the report of the Treasurer to the Auditing Committee.

THE PRESIDENT: Is there any new business to come before the House of Delegates tonight?

DR. WHITTIER: Mr. President, I ask that the financial report of the Committee on Venereal Diseases be referred to the Auditing Committee.

Thereupon it was voted to refer the financial report of the Committee on Venereal Diseases to the Auditing Committee.

THE PRESIDENT: Before we adjourn tonight, I will call for reports from the Councilors. The reports of the Budget Committee, the Nominating Committee, as well as these committees who have not yet reported, will take some little time tomorrow, and there will not be any time in the afternoon. Also we may as well decide on the time of the next House of Delegates' meeting.

DR. SPEAR: When does the Nominating Committee have to report?

DR. BRYANT: Usually at the last meeting of the House of Delegates.

Thereupon it was voted that the next meeting of the House of Delegates be held at Frye Hall, tomorrow morning, at 9.15.

THE PRESIDENT: The next thing is the reports of the Councilors. Dr. Thompson is not here for the First District. I will call on Dr. Call, of Lewiston, to report for the Second District.

DR. CALL: The only meeting I have attended was at Augusta, and I have nothing besides that to report. That was the time that we went down in regard to the osteopathy bill, and we feel that we stopped it before it went through with the alarming results the President has mentioned. That is the only thing that I have to report.

THE PRESIDENT: The next is the Third District, Dr. Barker, of Bath, who cannot be present. Dr. Turner, of Augusta, is present, and I will state that this covers the visits to the county societies which form the District.

DR. TURNER: Mr. President, the Fourth District, comprising Waldo, Somerset and Kennebec Counties, held a joint meeting last summer, together with Franklin County, at the Fairfield Sanatorium. This meeting was well attended and we had as a guest the President of the Maine Association. The Kennebec County Society held but one meeting during the past year. That society has 70 members, which takes in all but five or six of the eligible physicians in the county. Somerset County held one meeting. They have about three-fourths of the eligible men in that county as members. The Waldo County Society was organized in May, 1917, with twelve members. They have held no meetings on account of the small number of men present. Of that 12, one moved away, one resigned from membership, and five entered the service, so it was impossible, with the small number who remained, to have any meetings last year.

THE PRESIDENT: The report for the Fifth District, Dr. Miner, of Calais.

DR. MINER: Mr. President and Gentlemen of the Council: As Councilor for the Fifth District, I wish to report as follows:

For Hancock County.—

Twenty-two members in good standing; four members in the army service. One member, Dr. Chas. C. Morrison, Jr., of Bar Harbor, joined the society. Dr. J. G. Hutchings, formerly of Stonington, now of Camden, in the U. S. service, has been transferred to the Knox County Society. Major Harrison B. Webster, of Castine, was killed on the field of battle in France, on October 17, 1918.

This society has four meetings annually, May, July, August, and December. There is a substantial balance in the treasury.

G. A. NEAL, M. D., *Secretary*.
Southwest Harbor.

For Washington County.—

Thirty-five members in good standing. Dr. Cranston, of Calais, died in December, 1917. Three members joined in the last two years. Three members dropped from the books for non-payment of dues. Two members resigned. Two members transferred to other societies.

This society has three meetings annually.

There is a good working balance in the treasury.

I have had the pleasure of visiting the Hancock County Society on one occasion. I have attended most of the meetings of the Washington County Society in the last two years. Would like to report that in my opinion both societies are in good, flourishing condition. Their entertainment is practical, such as case reports, clinical cases for diagnosis, examination of patients and discussion of their symptoms and treatment. This method of entertainment makes it very profitable to those who attend these meetings.

I would like to recommend this kind of entertainment in the different societies, as I think it most helpful.

W. N. MINER.

THE PRESIDENT: The report for the Sixth District, Dr. Burgess.

DR. BURGESS: Mr. Chairman and Delegates:

I have not a great deal to report. My home county society, Penobscot, has had its usual number of meetings, one each month, with a banquet and a fairly large attendance. The most of the meetings throughout the year have been of a military nature. Aroostook and Piscataquis counties I have been unable to visit. They, as I understand, have had a very few meetings throughout the year on account of the large number of men away and the extra amount of work consequently put upon the men at home; but I am in hopes that the Councilor next year will be able to make a more flourishing report.

THE PRESIDENT: Immediately after adjournment this evening, the Council are requested to meet and go over the budget and the report of the Treasurer. A motion to adjourn is in order.

On motion of Dr. Gehring, adjourned until tomorrow morning at 9.15, at Frye Hall.

SECOND MEETING OF THE HOUSE OF DELEGATES.

FRYE HALL, JUNE 18, 1919, AT 9.15 A. M.

The meeting was called to order by President Coombs.

THE PRESIDENT: I will try and get in as many reports of committees this morning as possible. Report of Visitors to the Maine Medical School, Dr. Sturtevant.

REPORT OF THE VISITORS TO THE BOWDOIN MEDICAL SCHOOL.

To the President and Members of the Maine Medical Association:

GENTLEMEN: Your committee chosen to visit the Bowdoin Medical School would respectfully report that their visit was delayed this year by reason of the stress of circumstances, namely, the absence of so many of the profession in the service and the recent influenza epidemic, which compelled us to remain at our posts of duty. We, however, visited both departments of the Medical College at Portland and Brunswick and were most cordially received by the faculty at both places. There were 44 students in the school, with the larger number, 17, in the Senior class. We were impressed by the methods of teaching and the knowledge of the students on the subjects treated.

The result of the close contact of faculty and student, not only in the classes, but at the clinics at the Maine General Hospital and also at the Dispensary, was to our minds an improvement over the older methods of teaching at long range. We had the pleasure of witnessing a minor operation by one of the students under the direction of the Professor, which seemed a step in the right direction in clinical teaching.

As a member of your committee in 1897, with the late Dr. Wallace K. Oakes as a co-member, we recommended the removal of the upper classes to Portland by reason of the better opportunity for clinical teaching, both at the bedside and in the operating room, and the realization of the recommendation, with its results, was an added pleasure.

The visit to Brunswick was short but interesting, as we attended a demonstration on the cadaver, the students making the demonstration under the guidance of the instructor. The quiz attending this demonstration showed the subjects well understood, as the whole class participated in the discussion.

Professor Whittier kindly showed your committee the different points of interest throughout the laboratory and gave us a résumé of the work that department was doing, and I can assure the members that it was advanced work. We had the pleasure of visiting the new Dudley Coe Infirmary, endowed by Dr. T. U. Coe, of Bangor, and found it complete in its appointments and a most useful addition to the College and Medical School.

The Medical School celebrates its centennial next year. It dates from 1820, when it was established by the first Legislature of the new State of Maine and made a department of Bowdoin College.

From your committee's visit we are of the opinion that the Medical School is doing excellent work; that there is no reason for medical students to leave Maine for a medical education. We also believe that the Medical School should receive the earnest support of every physician and surgeon of the State.

GALEN M. WOODCOCK,
JAMES S. STURTEVANT.

It was voted to accept the report.

THE PRESIDENT: Referring to the work we took up last night, are there any committee reports to be made?

DR. BRYANT: The Budget Committee is ready to report. The Budget Committee make an estimate of the following expenses:

For Committee on Venereal Diseases,	\$25.00
President's expenses,	\$100.00 to \$150.00

(It was voted last year that all the President's expenses incurred in visiting the various local societies should be paid. We have put down there \$100 to \$150. Dr. Coombs estimated that would be about what the expenses would be.)

Journal of the Medical Association,	500.00
Legislative Committee,	300.00

(We have put in this amount because we have an idea that probably the Legislative Committee will get together and do some work, reporting to the next meeting, prior to the convening of the Legislature the following year. This fund will be at the disposal of the committee if they desire to use it.)

Secretary and Treasurer,	\$100.00
Expenses of the delegate to the American Medical Society, approximately,	200.00

This makes a total appropriation of	<u>\$1,300.00</u>
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Now if we should drop our dues to two dollars a year, we would only have an income of \$1,400, so there would be absolutely nothing left with which to meet the expenses of the annual meeting. Therefore, if we are going to keep up and pay our expenses, it will be necessary to hold our dues where they have been for the past two years, and that will be a subject to be voted on by the Delegates as to what the annual dues shall be for the ensuing year.

THE PRESIDENT: Gentlemen, you have heard the report of the Budget Committee, and the principal element is the question of dues. Before taking that up, however, what action shall we take on the report of the Budget Committee?

Voted to accept the report.

THE PRESIDENT: There is much work to be done by the Legislative Committee in the interests of this Association. We have the medical license law, which certainly is coming up at every session of the Legislature unless we develop a law which is satisfactory to this Association and which safeguards the interests of the public. That gives an opportunity for some very live work by the Legislative Committee. The public health laws that are being developed are of the utmost importance, and that work should be threshed out also. Then there is a subject that is of vital importance to us all, namely, the question of the appointment and fitness of the work of the medical examiners in this State. There is no subject which affects the tone of the medical profession more than the work of medical examiners before the courts. In order to take up this subject, it is necessary that

this work should be done from now on, and it is necessary to provide funds for that purpose. Your committee last night voted \$300, and to pay the expenses of the delegate to the American Medical Association. Practically it was agreed to continue one man in service in order that we may get the most good out of it. That requires an annual expenditure. It was also voted to pay the expenses of the President of this Association in his visits about the State, and wherever he may live but few of the county societies can be visited by him at an expense of less than ten dollars; and, if he lives in Cumberland County and goes to Aroostook County, excepting by the air route, it will cost him more than that. For that reason they have voted a sum of from \$120 to \$150 for that purpose. That brings us to the point where, in order to keep up a healthy financial condition, we must have a steady inflow of cash, and it is for us to determine today whether we will continue the dues at four dollars or reduce them. A motion is in order.

DR. SINCOCK: Mr. President, if it is in order, I move that our dues for the coming year be the same as the past, four dollars. The motion was seconded.

DR. GARCELON: Mr. President, I would like to inquire if this action is final; if this action obligates the Maine Medical Association to that?

THE PRESIDENT: Yes.

DR. GARCELON: It seems to me, Mr. President, that that is a question that involves every man in the Maine Medical Association, and personally I believe that before any positive action is taken of that character it should come before the general meeting of the Association. Personally I am in favor of it; but there has been some criticism of the House of Delegates, and a lot of men have expressed the idea that these actions that we take should be carried through as a committee and brought up before the general session before we pass on it. Whether or not it is a good time to bring that subject up now or later is a question, but personally I feel that the action that this body takes should be ratified by the general meeting. I think in this way that the action of this body, not only in this matter, but with reference to all other matters of importance, will be up before the general body and more interest will be aroused.

DR. MASON: Mr. President, I would like to inquire if the vote taken two or three years ago, that one session of the House of Delegates should be in open house with the general body, still stands?

DR. BRYANT: It has not been rescinded.

DR. MASON: Two or three years ago it was voted that one session of the House of Delegates should be in open house, so that the members generally might have the opportunity of discussing any special matter.

DR. SPEAR: We have had one open meeting every year for the last few years.

DR. GARCELON: I know I appeared before the House of Delegates last year on the workmen's compensation act, an act that affected us particularly, and in some way or other there was no action taken on that by our Legislative Committee. It seems to me that these matters affect the whole State, and in order to bring them before the general view of our medical profession, we have got to do something whereby we can throw them into relief, and we do not succeed in this by printing the proceedings of the House of Delegates.

THE PRESIDENT: It seems to me that the suggestion of Dr. Garcelon is a good one. It will place the responsibility for the dues upon the entire body. I believe that the House of Delegates has full authority to regulate the question of dues, but the Chair will entertain a motion to table this and refer it to the general session.

DR. SINCOCK: Mr. President, could not this question be brought up in the House of Delegates when we have our open meeting, and then anyone who wished would have a chance to come in on these questions?

THE PRESIDENT: Yes, it can be tabled now and brought up at a meeting of the House of Delegates in open session, or we can bring it before the full body.

DR. SINCOCK: It seems to me that all questions that we can decide satisfactorily should be decided by the Delegates, because our general meetings in the past have not taken up general business. Of course, if it was necessary, it could be done, but that is what I understand this House of Delegates is for, to do up the business so that during our regular sessions we can listen to interesting papers.

THE PRESIDENT: The Chair would like to inquire of Dr. Mason if he understands that that vote referred to an open meeting of the House of Delegates or a meeting of the full Association?

DR. MASON: I think it must be on the records somewhere. The vote, as I remember it, was a vote of the society that one meeting of the House of Delegates should be an open session with the general

body, so that questions—for instance, of this kind—might be subject to general discussion and a general opinion be arrived at before the House of Delegates settled upon it. I understand that the settlement of the question remained with the House of Delegates, just as before, but it was discussed in open meeting. These various questions that would affect the whole society were to be discussed in open meeting so that everybody would have a definite idea of them.

THE PRESIDENT: In order not to interfere with the clinic, I will give notice here that there will be an open session of the House of Delegates immediately following Dr. Spear's paper Thursday morning, and this question will be tabled until that time. I will entertain a motion to that effect.

On motion by Dr. Sincock, it was voted to table this matter until the open session of the House of Delegates Thursday morning.

THE PRESIDENT: Are there any other reports to be made at this time? Dr. Miner, have you a report?

DR. MINER: Mr. President, your committee appointed to consider the fee schedule of the physicians and surgeons of this State beg leave to report that in their opinion it is best not to consider the same at this time. Signed on behalf of the committee by Drs. Garcelon and Miner.

On motion by Dr. Spear, it was voted to accept the report.

Adjourned subject to the call of the President.

FIRST GENERAL SESSION, MAINE MEDICAL ASSOCIATION.

HELD AT

Portland, Maine, Frye Hall, June 18, 1919.

The meeting was called to order by the President, Dr. George Coombs.

Invocation by Rev. Dr. James F. Albion.

THE PRESIDENT: Are there any visiting delegates here from other State societies?

DR. CHARLES A. DENNETT: Mr. President, I am a delegate from the Massachusetts Medical Society.

THE PRESIDENT: We are very glad indeed to welcome Dr. Dennett, and ask him to address us.

DR. DENNETT: Mr. President and Members: I have been a member of the Maine Medical Association for nearly thirty years, and have kept somewhat in touch with the proceedings of this society. I have been a member of the Massachusetts Medical Society for more than twenty years, and have served that society in various capacities. In the town where I live, five of the physicians are from the State of Maine, and all over the Commonwealth there are scores of physicians who formerly lived in Maine. Why we all should ever leave such a wonderful State, with its unsurpassed natural beauties and advantages, is almost beyond comprehension; and if we had all stayed at home I think we would have been fully as well off. I wish to extend greetings to the Maine Medical Association from the Massachusetts Medical Society. Many of the physicians in Massachusetts who came from Maine are among the very leaders, and every one of them, I think, is a credit to the Pine Tree State. It gives me, Mr. President, very great pleasure to be here at this time as a delegate from the Massachusetts Medical Society. (Applause.)

THE PRESIDENT: It certainly is very gratifying to hear this tribute to the State of Maine and to her sons who are in the practice of medicine in Massachusetts.

In order to save time while waiting for Dr. Hitchcock, your President will read his annual address.

(Dr. Bryant in the Chair.)

Dr. Coombs reads.

DR. JACKSON, of Houlton: Mr. Chairman, I would like to make one suggestion in regard to Dr. Coombs' remarks, namely: Why would it not be a good thing for the Committee on Public Health and Legislation to present before this Association at its next annual meeting a summary of the various suggestions that we are going to make at the next session of the Legislature? Dr. Coombs knows, and everybody else knows, that coming in before a Legislature with eleventh-hour suggestions does not produce good results. I think if this Association can discuss in open meeting the suggestions that its Public Health Committee will present at that time, we will accomplish something, but if we simply leave it to the committee to present, without the voice and approval of the State society, I do not think we will get very far.

THE CHAIRMAN: You have heard the remarks of Dr. Jackson. This is a very vital question with us. It seems to me that we could entertain a motion to have a few remarks with reference to this point right now. I believe that the next session of this Association should have given to it an outline—perhaps a written report—of different ideas as to the best method of making these changes in our laws, and that there should be sufficient time given for them to be threshed out on the floor of this Association. I believe that the work of your Legislative Committee should be with us all the time; that there should be no awaiting the action of some particular interest; and, if there is a desire on the part of the members present to take this matter up now, I think we may well entertain a motion to do so.

DR. KERSHNER, of Bath: Mr. President, a few years ago this question came up regarding the osteopath bill, the same as obtains now in regard to public health measures. The chairman of the Legislative Committee promised to have the thing fixed up right; but, as a matter of fact, they did not have it fixed up right, and the State Legislature passed the most diabolical thing ever passed by any Legislature. It seems to me there must be some way of getting at this besides through a committee. The committee are men of business and their minds must be concentrated on their own affairs, and it is an actual impossibility for those men to be studying the thing and attending to their business at the same time. That has been proved in two or three different ways. Another mistake was the matter of hiring the lawyer, depleting the treasury thereby. To bring the matter to a head, Mr. President, I move that a committee be appointed by the Chair to investigate the best methods of presenting these laws to the Association, to study the question and to report at this meeting. In studying the whole problem, there are many factors to be taken into consideration. Every one of us is at fault that that bill went through last year. We cannot lay that to any one man. Now considering that fact, we have got to lay the blame at our individual doors, because we should all be interested to keep track of these things as much as any committee. Therefore, I make a motion that a committee be appointed to investigate what sort of methods will yield the best results.

THE CHAIRMAN: Do you have in mind reporting at this meeting, Dr. Kerschner?

DR. KERSCHNER: At this session.

THE CHAIRMAN: A query arises whether the Legislative Committee could not do that work as well as a new committee, but I put it to the house for seconding.

The motion was seconded by Dr. Bennett. A *viva voce* vote being taken, the motion failed of passage.

DR. DOBSON: I move that the Legislative Committee bring in a report at this session on this subject.

THE CHAIRMAN: I will say that a new Legislative Committee has not been appointed, and there is no member of the old Legislative Committee present. A new committee will be appointed by the House of Delegates very shortly, and we will transfer the duty to them. I believe that the time would be too short to investigate and report at this session, and that as soon as we can get an intelligent report is the next session.

DR. JACKSON: Mr. Chairman, I might add that they bring in their suggestions at the next meeting, thus giving us plenty of time. This is an important matter, and, if we do not have it right, we will be beaten again. One of the most influential men of the Legislature told me that the reason the bill referred to went through was because there was no opposition. Now, Dr. Bryant says this Legislative Committee goes out of existence to-day or to-morrow, so let's appoint one to go and do the work, and bring in at the next June meeting a set of suggestions that can be threshed out in open meeting. If we want to change them then, we can do so and then stand behind them. If the committee then goes before the Legislature and voices the sentiment of this society, perhaps we will get some recognition.

DR. KERSHNER: I think, Mr. Chairman, that is the very best suggestion, for it brings up what we have not done in the past. We have only had a hit-or-miss system. If the society appoints a constructive committee, and has that in mind, we cannot help succeeding.

THE CHAIRMAN: Does Dr. Dobson accept the amendment to report at the next meeting?

DR. DOBSON: Yes.

And the motion as amended prevailed.

PRESIDENT COOMBS in the Chair: The first paper of the morning is upon a subject which affects us as much as any other with which we have to deal. I take pleasure in introducing to you Dr. Hitchcock, who is the Division Director in the control of venereal diseases in this State for the Federal Service, and who will speak on "The Control of Venereal Disease in Maine."

Dr. Hitchcock reads.

On motion by Dr. Sawyer, it was voted to refer the President's address to the Legislative Committee.

DR. SAWYER: I want to make another suggestion, Mr. President, and that is that we adhere to the rules, otherwise we are liable to stay here until the Fourth of July.

THE PRESIDENT: This venereal topic seemed to be of so much interest that I felt it better to continue it. The remainder of the session will be confined to the time limit. We will now listen to the report of the necrologist, Dr. Spalding.

DR. SPALDING: Mr. President, I regret that County Secretaries in the case of death of members are apt to forget the labors of your necrologist, and I remind them once more that it would save much time, research and expense on his part if they would forward a simple newspaper cutting whenever accessible. If there are any omissions in my list, I beg the excuse of not being able to read every newspaper in Maine or every medical journal in the United States.

REPORT OF THE NECROLOGIST FOR 1918-19.

The war is now over and once more we meet together. A year ago many of us feared that few of our members would ever return home again. Fortunately, however, most of them are at work again, as well as ever, but improved in physique, increased in knowledge, and they have made themselves more capable members of the profession than ever before. What they have learned in war will now show itself daily in peace, in their work for the benefit of the people of the places in which they practice, and indirectly for the physical welfare of the nation. They have shown us a brave example for the State and the Nation. To them, our thanks for going forward.

The only member of our Association killed on the field of battle was Harrison Briggs Webster, of Castine, concerning whom appreciations by other members have been printed in the JOURNAL of our Association, and sadly read in order to catch a glimpse of the noble fellow that he was. To the memory of Dr. Webster, of Castine, we give hearty thanks, in that he sacrificed his life to save us all.

Four others in all have died in active duty, one of whom, Wyvern Almon Coombs, who was eulogized in the report for last year, and he, with the others next to be mentioned, shall be enrolled upon our list of heroes of the war just as if they had been killed on the field of battle or lost at sea. William Edward Emery, Bangor, died from meningitis following an operation. Carl Dinsmore Gray died on the threshold of his home in Portland as a result of overwork in camp. Herbert Martin Howes, of Brunswick, not a member at the time, but on our waiting list for the year, died from the sequelæ of influenza contracted in arduous labors in camp.

The gratitude of the Association is due to them all for their labors and sacrifices, and our sympathy goes out unsought to their widows and children. They did their part valiantly to save the world from the domination of Germany

The motto of that nation, never to be forgotten, was to dominate the world or to go to ruin. That was their choice and their will. Let them abide by it, now that the end for them has been attained, by the sacrifices of our members and thousands of our brave soldiers.

In addition to the heroes enrolled above, the following members have departed from our ranks during the past year:

Andrew Allen Brown, Bangor, hospital superintendent in the West.

Albert Henry Burroughs, Westbrook, careful practitioner of medicine.

John Augustus Donovan, Lewiston, former President of this Association.

Harry Everett Gribbin, Rockland, oculist and also laryngologist.

Pearl Tenney Haskell, Bangor, superintendent of the Eastern Maine State Hospital.

Frederick Lyman Hills, famous alienist at Bangor, and superintendent of the State Hospital.

Albert Wilson Nash, sturdy practitioner at North Haven.

William Peter McNally, Bangor, genial diagnostician.

Joseph White Humphreys Porter, Caribou, oculist.

John Watson Sawyer, Dexter, hard-working physician.

William Seward Thompson, Standish, careful country physician.

Walter Adams Wright, Readfield, veteran and nestor of the profession.

Concerning the career of these various members brief biographical appreciations have been, or will ultimately be, printed in the JOURNAL.

JAMES A. SPALDING, *Necrologist*.

Adjourned.

Second General Session.

JUNE 18, 1919, 2.00 P. M.

Meeting called to order by President Coombs.

THE PRESIDENT: We will listen to a paper by Dr. W. E. Kershner, of Bath, on "The Development and Operation of Our Base Hospitals."

Dr. Kershner reads.

THE PRESIDENT: The clinic at the Children's Hospital will not begin until 3.30. I wish to make the announcement that in accordance with the vote of this Association two years ago, a general meeting of the House of Delegates will take place to-morrow forenoon after the last paper. This is a most important meeting. The matter which is to be brought up is the question of dues, for one thing, and it is desirable that every member of this Association who can do so shall be present. The questions of expense of medical defense, the work of the Legislative Committee, the expenses of the delegate to the National Medical Association, and so on, are all interwoven with the question

of dues, and so we ask that as many as possible will remain to that meeting of the House of Delegates in order that we may get expression from them as to what our dues shall be for the coming year; also to take up other questions which the House of Delegates may agree to refer to the general session.

I am asked to request all those who expect to attend the shore dinner to secure their tickets in order that the committee may know something of the number who will be present. You are aware by the program that we are the guests of the Cumberland County Association at a shore dinner to-morrow at 6.30. On account of the fear of unfavorable weather conditions it was decided to have that dinner in the dining room in the lower part of this building. It will be a shore dinner just the same, though you will not be able to hear the lapping of the waves or to have the preliminaries, perhaps, of seasickness.

We have sufficient time for another paper before we attend the clinic, and Dr. Wakefield has kindly consented to give his paper at this time on "Reflex Symptoms of the Upper Abdomen Caused by Chronic Appendicitis."

Dr. Wakefield reads.

THE PRESIDENT: Gentlemen, there is not time to take up anything further before attending the clinic at the Children's Hospital, at the corner of High and Danforth Streets, at 3.30. This evening Dr. Cabot will give a talk on social service in connection with hospitals, and there is no one in New England better fitted to do so than he. It will be an open meeting, and we will be very glad to have you bring your wives and fill the hall. It will be of interest to everyone.

Adjourned.

Third General Session.

JUNE 19, 1919, 9.00 A. M.

The meeting was called to order by President Coombs.

THE PRESIDENT: We will listen to a paper by Dr. W. M. Spear, of Rockland, on "How to Reduce the Mortality Rate in Cancer."

Dr. Spear reads.

THE PRESIDENT: The next paper is one by Dr. Powell, of Saco, on "The Treatment of Pneumonia as Suggested by Recent Clinical and Bacteriological Findings."

Dr. Powell reads.

THE PRESIDENT: Gentlemen, your House of Delegates now come to you for your assistance. They wish to take up with you two or three questions which they feel you can help them to answer. You are aware that in carrying out the relief of members of the Association who were in the service, and the feeling that we wished to retain them as members, the dues of the Association were raised to four dollars. It was the unanimous opinion of the House of Delegates at the meeting in which this came up that four dollars should continue to be the dues of the Association, for this reason: It was a coincidence merely that they recommended what I have happily placed in my address that the delegate to the American Medical Association should be one already familiar with the work of that Association, if possible, and that he should be continued in office at least for two years, in accordance with the by-laws of the parent association, and beyond the two years if possible. If you will read the reports of the American Medical Association for this year you will find that some of the delegates and officers have been in attendance for as much as fourteen years. You can readily understand their value to the medical profession because of their long service. Now if we are to have proper representation and are to make the influence of this Association felt in the parent body, we must be represented by someone who is aware of the conditions here and who is familiar with the machinery of the Association. In order to make it possible for that delegate to be present at all meetings, however distant those meetings may be, it was the unanimous opinion of the House of Delegates that the expenses of that delegate should be paid by this Association. That was one of the reasons for increasing the budget recommendations upon which our need for funds must be based. Your Budget Committee recommends that to the Committee on Venereal Diseases shall be awarded twenty-five dollars for the year—they already have quite a fund. It was voted last year to pay the expenses of the President of the Association in visiting the various county societies, and his other work, and it was estimated that this would be from one hundred to one hundred and fifty dollars. You know that the by-laws require that the President shall visit every county society once during the year. To the JOURNAL was given five hundred dollars; to the Legislative Committee three hundred dollars; to the Secretary and Treasurer one hundred dollars, as usual; expenses of delegate to the American Medical Association, two hundred dollars. This all amounts to approximately thirteen hundred dollars. Our dues, if we have 700 members for the next year, as we undoubtedly

will, at two dollars, would only bring in about enough to pay these expenses. The time is approaching, if it is not already here, when we must take up for our own benefit the question of medical defense: and while we have now in the treasury some \$3,988, less about \$128 in bills that have been paid since the report was made, the House of Delegates feel that now is the time for us to prepare for the adequate carrying out of the medical defense plan. That is one of the reasons why they recommend the retention of the dues at four dollars. We ask, therefore, that you vote upon this question, and I am going to ask for a hand vote of those present upon the question whether our dues shall remain at four dollars. Prior to that vote being put, I think it is right that you should have an opportunity to be heard in the matter. If anyone wishes to ask questions or to talk, the subject is open for discussion.

I forgot one thing! It is also the opinion of the House of Delegates that it will be for the advantage of the Association, and interest in its work will be increased, if we have our meetings at different places. We also feel that we would like to relieve those living in the sections where these meetings are held from the expenses. In other words, we would like to pay our own bills, and this is an added reason for keeping our treasury in good condition.

Is there anyone who wishes to say anything on the question of dues? If not, I will put it to a vote. Shall our dues remain at four dollars? I do that because in town meetings, you know, one can start at a high figure and come down, but cannot go up. Shall our dues remain at four dollars? All those in favor of their so remaining will please signify it by raising their hands.

There being no hands raised in opposition, it was voted to continue the dues at four dollars.

DR. GILBERT: Your Committee reports favorably on the following:

THE PRESIDENT: Gentlemen of the House of Delegates and of this Association: There are two sub-committee reports before we take up the last business, which is the election of President. A sub-committee was named to report on the matter of requesting the governor to insert in his call for a special session of the Legislature a notice to take up the matter of compulsory examination in the schools. Is that committee here to report?

Considering that nearly one-half of the recruits from Maine in the recent war were unable to fight for the nation owing to physical deformities, which might have been discovered and largely relieved in childhood, the Maine Medical

Association now in session urges Governor Milliken to incorporate in his call for any extra session of the Legislature the imperative necessity of legalizing compulsory physical examinations of all the school children in Maine in place of the present voluntary system, and compulsory physical training.

FRANK Y. GILBERT,
H. W. GARCELON,
J. A. GREENE.

Moved and seconded the adoption.

THE PRESIDENT: Also a sub-committee named to report as to whether this Association should make protest or take action on the increase in the internal revenue tax for the use of narcotics from one dollar to three dollars. Is that committee ready to report? (No response.)

THE PRESIDENT: Is it the sense of this Association that it wishes to take any action with reference to this matter? If so, the Chair will entertain a motion with reference to it. If not, we will proceed to the election of President, and nominations are in order.

DR. KIRSHNER: Mr. President, it gives me great pleasure at this time to nominate a man, a friend of mine in my younger days, who has been a member of this Association for a great many years, and who is responsible probably more than any other one man for the success of the most successful county society in this State, a man whom I believe two years ago very courteously withdrew after being nominated in favor of a brother physician, and it gives me great pleasure to nominate Dr. Mason, of Calais, as President of the Association for the ensuing year.

The nomination was duly seconded by Dr. Smith of Portland.

THE PRESIDENT: Dr. Mason, of Calais, has been nominated as President, and that election is by ballot. There being but one nomination, the Secretary may be instructed to cast the ballot of the Association for Dr. Mason, of Calais, as President.

DR. SMITH: I move you, Mr. President, that the Secretary cast the ballot of the Association for Dr. Mason as President for the ensuing year.

The motion being duly seconded, the Secretary thereupon attended to his duty and cast the ballot of the Association as above indicated, and Dr. Mason, of Calais, was declared duly elected President of the Association for the ensuing year.

PRESIDENT-ELECT MASON: Gentlemen of the Association: I thank you very much for the honor which you have conferred upon me, and I assure you that I will endeavor to fulfill the duties of President to the best of my ability and for the best interests of the Association. I thank you. (Applause.)

On motion of Dr. Thayer, of Portland, the thanks of the Association were extended to George C. Frye for the use of Frye Hall without charge during the convention.

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The motion prevailed, and the Secretary cast the ballot of the Association for the nominees reported by the Nominating Committee.

Adjourned until 1.30 P. M.

THE PRESIDENT: We suggest, gentlemen, that instead of having a closed meeting of the House of Delegates, we call upon the Nominating Committee to give their report at this time. There may be some things in relation to it which you would like to discuss. Dr. Spear is the chairman of that committee.

DR. SPEAR: Mr. President, your committee begs leave to submit the following report:

<i>President,</i>	DR. H. B. MASON, Calais.
<i>First Vice-President,</i>	DR. LINDLEY DOBSON, Presque Isle.
<i>Second Vice-President,</i>	DR. CARL STEVENS, Belfast.
<i>Secretary and Treasurer,</i>	DR. B. L. BRYANT, Bangor.

COUNCILORS.

First District,	DR. JOHN F. THOMPSON, Portland.
Second District,	DR. E. V. CALL, Lewiston.
Third District,	DR. B. F. BARKER, Bath.
Fourth District,	DR. OLIVER W. TURNER, Augusta.
Fifth District,	DR. LEWIS HODGKINS, Ellsworth.
Sixth District,	DR. C. H. BURGESS, Bangor.

COMMITTEES.

Scientific Work. Dr. F. C. Tyson, Augusta; Dr. S. J. Beach, Augusta; Dr. H. E. Thompson, Augusta.

Public Policy and Legislation. Dr. G. H. Coombs, Waldoboro; Dr. R. D. Simons, Gardiner; Dr. A. P. Leighton, Jr., Portland.

Veneral Diseases. Dr. F. N. Whittier, Brunswick; Dr. A. L. Stanwood, Rumford; Dr. R. A. Holland, Calais.

Cancer. Dr. H. E. Thompson, Augusta; Dr. E. S. Cummings, Portland; Dr. W. N. Miner, Calais.

Necrology. Dr. J. A. Spalding, Portland.

Public Health among Women. Dr. L. B. Hatch, Portland.

Hospitals. Dr. W. N. Miner, Calais; Dr. W. L. Cousins, Portland.

Delegates to the American Medical Association. Dr. B. L. Bryant, Bangor; Dr. F. Y. Gilbert, Alt., Portland.

Delegate to National Council Medical Education. Dr. F. N. Whittier, Brunswick.

Delegate to National Legislative Council, Dr. G. H. Coombs, Waldoboro.

Delegate to State Anti-Tuberculosis Meeting. Dr. F. J. Welch, Portland.

Delegate to New Hampshire Medical Society. Dr. J. A. Spalding, Portland.

Delegate to Massachusetts Medical Society. Dr. W. C. Peters, Bangor.

Visitors to State Sanitariums. Dr. F. J. Welch, Portland; Dr. Carl O'Brien, Bangor; Dr. Estes Nichols, Portland.

BERTRAM L. BRYANT, *Secretary.*

THE PRESIDENT: Gentlemen of the House of Delegates, do you accept this report?

Thereupon it was voted to accept the report.

THE PRESIDENT: Gentlemen, one of the duties imposed on you by the by-laws is the selection of a place for the next annual meeting. I wish to say that there has been a suggestion made, in view of the wonderful success of the clinic which was held yesterday, that Augusta has an insane hospital where a psychopathic clinic could be held. It

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also has a laboratory for diagnosis where the opportunities for laboratory diagnosis could be demonstrated. With that in mind, the Scientific Committee feels that, unless some other place is strongly urged, it would be well to go to Augusta. This, it was felt, could be done without embarrassment to the doctors in Kennebec County if we did as we felt we should do—pay our own bills. The question now is as to where the next meeting of this Association shall be held, and the Chair is ready to entertain a motion from the House of Delegates, and we would like assistance from anyone else.

On motion, duly seconded, it was unanimously voted to hold the next meeting at Augusta.

THE PRESIDENT: The date will be settled later, and must agree with the work of the American Medical Association, as well as with the inclination of our members, so many of whom like to attend Bowdoin commencement and cannot take two trips. I would also like to say that there will be a meeting of the Council immediately after this meeting. One of the duties of the Council is to outline the work for the coming year.

DR. WILLIAMS: Mr. President, if I remember correctly, the officers nominated by the Nominating Committee have to be elected by ballot of the House of Delegates, and I move that the Secretary cast the ballot of the House of Delegates for those officers as nominated.

Fourth General Session.

JUNE 19, 1919, 2.00 P. M.

The meeting was called to order by President Coombs.

THE PRESIDENT: Many members of this Association who went into camp for service were fortunate enough to be assigned to Devens, and there they had as their mentor, as their guide, counselor and friend, one who is with us to-day and who will give us a talk on base hospitals. I take great pleasure in introducing to you Dr. Channing Frothingham, of Boston. (Applause.)

DR. FROTHINGHAM: I thank the President for his kind words about some of my fellow officers at Camp Devens, because I had the opportunity the other day of looking after the wife of one of them who had gone overseas. She said, "Why, Doctor Frothingham! I'm awfully glad to meet you. You are not such a terrible creature after all. My husband thought you was the darndest tyrant in the world when he was under you up to Camp Devens." (Laughter.)

Dr. Frothingham speaks.

THE PRESIDENT: We have indeed been fortunate in having Dr. Frothingham talk to us on this subject. Doctor Frothingham must take the train in a little while, and shall we not now give him a rising vote of thanks?

Thereupon the convention extended to Dr. Frothingham a rising vote of thanks.

THE PRESIDENT: One of the unhappy features of a doctor's life is the grilling which may come to him as a witness in criminal trials. We have become painfully aware that many of the features of our medical examiner law in this State are very, very imperfect, to say the least. Your Program Committee has secured Dr. Leary, of Massachusetts, who has had extended experience in this line, to give us an idea of the important features of the medical examiner work in Massachusetts. Also we are able to take up the discussion from a legal standpoint. I take pleasure in introducing to you Dr. Leary. (Applause.)

Dr. Leary reads.

THE PRESIDENT: Shall we not express our thanks to Dr. Leary and to Judge Wilson by a rising vote.

Thereupon the audience rose.

THE PRESIDENT: Happily your program committee was able to secure one for your annual oration whom many of you know and love, and whom they feel that you all should have the opportunity of knowing and loving. I take great pleasure in introducing to you Dr. Banks. (Applause.)

Dr. Banks reads.

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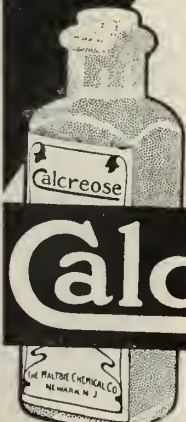
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